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Blood Pressure Determination

A Nursing Procedure

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A patient is admitted to the emergency ward of a general hospital in coma with the history of a recent and severe trauma to the head. Appreciating the gravity of the situation the house officer completes only the absolutely essential details of the physical examination and meets the immediate indications. Cerebral compression is his first impression. The staff physician is called and to him also occurs the necessity for the consideration of a cerebral compression in explanation of the continued unconsciousness. Further close observation of the patient alone may establish this point. To the old familiar orders for observation of the patient for convulsive movements, the rate and state of the pulse and of the respiration, is added, "The nurse will record the blood pressure every fifteen minutes."

USAGE itself would seem to justify this new order of affairs, but after all no mysterious nor difficult technic is involved in sphygmomanometry, as the study of blood pressure may be correctly termed. However, in accepting this responsibility the nursing profession presupposes for its component members a working knowledge of hemodynamics, particularly in so far as blood pressure may be affected.

The term, blood pressure, is a loose one, for it is apparent to the most casual that the pressure of the blood will be a most variable one dependent upon the position in the vascular bed at which it is determined. For example the pressure under which the blood leaves the heart, in the aorta, will greatly exceed that by which it is returned in the venae cavae. The term, blood pressure, may therefore refer to any site or location from the left ventricle back to the right heart and, for that matter, intracardiac pressures are constantly read in experimental animals. Clinically these observations are confined to the accessible peripheral arteries, capillaries, and veins; and in common parlance, medical as well as lay, blood pressure implies arterial blood pressure.

Factors Influencing Blood Pressure

REDUCED to simple terms the pressure of blood in the arteries is dependent upon three factors; namely, heart, blood, and peripheral resistance. The heart is the source of energy and upon its force of contraction, volume output per stroke, and

rate must depend many of the circumstances of blood pressure alteration. The volume and the viscosity of the blood are factors of lesser importance. The peripheral resistance is obviously one of the most important details in determining the arterial blood pressure. A given volume of blood is propelled from the left ventricle on cardiac systole. An elastic arterial bed accommodates this increased fluid mass and by its inherent power of contractility maintains the forward movement of the blood current and a measure of sustained pressure during the resting period of the heart. As the peripheral vascular bed is approached, and particularly after the arteries divide into their ultimate subdivisions or arterioles, there occurs a sudden fall in the pressure of the blood. Hence the pressure of the blood in the capillaries forming the next vascular link is much lower than in the arterioles. By reason of this sharp physiologic transition from the arteriolar to the capillary bed, the term "peripheral resistance" has arisen. The peripheral resistance in turn is subject to a number of varying influences.

From a glance at the conditions attendant upon the cardiac cycle it becomes apparent that the pressure in the arterial bed will undergo decided fluctuations arising from the alternate contraction and relaxation of the left ventricle.

On ventricular discharge or systole a peak of pressure, or systolic pressure, will be attained, whereas on ventricular filling or diastole the arterial pressure will fall to its lowest ebb, and this maintained low pressure of the resting period of the ventricles is termed the diastolic pressure. The difference between the systolic and the diastolic pressures is the pulse pressure.

Construction of Blood-Pressure Apparatus

FROM the earliest exact measurement of the arterial blood pressure by direct cannulation of the vessel, the practical application of an indirect method has been evolved. Regardless of the type of apparatus utilized, experimental and clinical study has established certain principles. In the first place the common forms of blood-pressure apparatus are composed of three essential parts; a constricting cuff to be placed about the upper arm or the thigh; a one-way air pump or bulb to effect increased pressure within this cuff; and a recording device, of which there are various types, appropriately connected to the cuff in order to measure the pressure necessary to cause certain changes in the peripheral arterial circulation. The constricting cuff is made of rubber of sufficient elasticity to avoid errors which might arise if an inordinate pressure were necessary to inflate the same. This cuff must be at least 10 cm. in width and should be enclosed in an inelastic binder, to eliminate further sources of error. As indicated, the pressure within the expansible cuff is increased by means of a one-way air pump or bulb, and gradual release of this tension is brought about by a needle valve, usually controlled by a thumb screw conveniently placed close to the air pump or bulb. The pressure within the cuff may at any time be determined through its reflection on the attached mercury manometer, which has a scale calibrated in millimeters. In the aneroid type of sphygmomanometer the mercury manometer has been replaced by a chamber of corrugated metal, which responds delicately to changes in pressure and reflects the same upon an attached dial. While

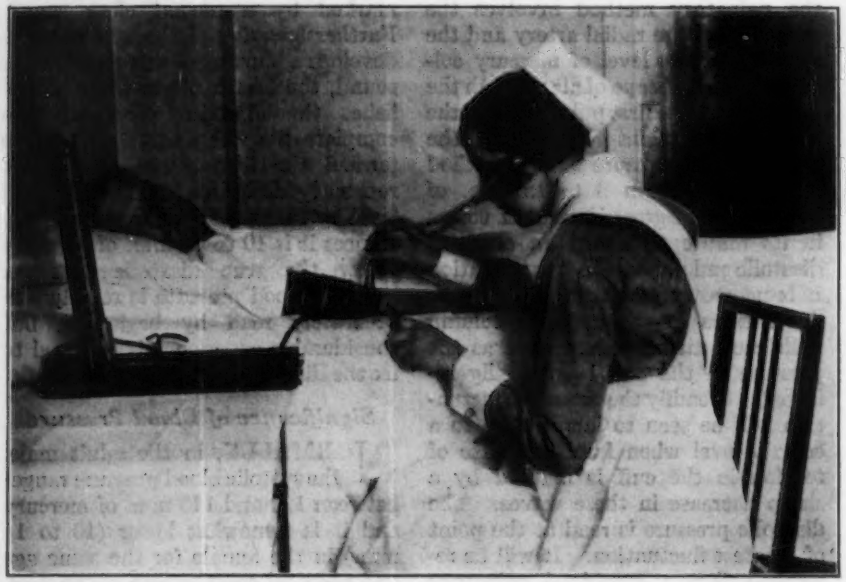

FIGURE I.—The auscultatory method of determining the blood pressure of a reclining patient

the aneroid sphygmomanometer is more compact and convenient, all such forms have the inherent source of possible error in alteration of the tension of the mechanical parts. In passing, the observer is cautioned to standardize any such apparatus against a mercury manometer at weekly or fortnightly intervals, in order to obviate discrepancies.

Technic of Blood-Pressure Taking

AS to the actual technic of sphygmomanometry the subject in the reclining or sitting posture places the arm comfortably at the side—if sitting, on a table; if reclining, on the bed. The arm and the blood pressure apparatus should be approximately at the level of the heart. The observer seats himself upon a chair drawn to the side of the arm under study. Successive readings should always be taken in the same position. The cuff is wrapped snugly about the upper arm without exerting any pressure. (In an infant or a small child the thigh and the popliteal artery may be utilized in preference to the arm.) Care should be exercised always to place the expansible cuff directly over the brachial artery or whatever vessel is under study. It is advisable that the elastic cuff be just short of complete deflation. Then by means of the attached rubber bulb the expansible cuff is distended steadily until the radial pulse is obliterated. From this level the pressure in the cuff is slowly reduced through the needle valve. Readings should be made as quickly as compatible with accuracy, avoiding continued pressure on the vessel and remembering that first readings may be elevated through psychic effects.

From this point one of two methods is available for the actual blood pressure determination. In the first place

the palpatory method involves the palpation of the radial artery and the notation of the level of mercury column when on escape of air through the needle valve the first pulse is felt at the wrist. This point constitutes the systolic blood pressure and the method is accurate within 8 to 12 mm. of mercury. Its great drawback comes in its failure to afford an accurate diastolic end point. In its application it is necessary to observe closely the fluctuations in the mercury column with each cardiac contraction as the pressure in the cuff is gradually released. Steadily the extent of fluctuation will be seen to increase up to a certain level when further release of tension in the cuff is marked by a sharp decrease in these waves. The diastolic pressure is read at the point of greatest fluctuation. It will be remarked that a combined palpatory and visual method is herein described, since there is no general clinical subscription to the palpatory reading of the diastolic pressure.

Within comparatively recent years the palpatory methods of sphygmomanometry has given way almost entirely to the auscultatory technic. By this method the arrangement of all details is the same, with the exception that the end points are established by auscultation of the brachial artery below the cuff, *i.e.*, just above the elbow, where the pulse of the brachial artery may be felt medial to the tendon of the biceps muscle. Certain sounds are audible on the gradual release of pressure in the constricting cuff. These have been termed the five phases. In most instances, the first auditory phenomenon is a clear sound and it defines the systolic blood pressure. On the further reduction of pressure in the cuff the second phase is denoted by a murmurish quality imparted to the first clear sound. The third phase is marked by a second clear sound. Further lowering of the cuff pressure develops a blurring of this second clear sound, the fourth phase which establishes the diastolic pressure. The complete disappearance of all sound is termed the fifth phase and is erroneously designated as the diastolic level by many teachers. In most instances it is 10 to 15 mm. of mercury below the true diastolic pressure. Systolic blood pressure is readily and accurately read by beginners, but considerable experience is required to fix the diastolic blood pressure.

Significance of Blood Pressure

NORMALLY, in the adult male, the systolic blood pressure ranges between 120 and 140 mm. of mercury and it is somewhat lower (10 to 15 mm.) in the female for the same age and physical constitution. The diastolic blood pressure ordinarily registers 80 to 90 mm. of mercury for the normal adult male. A rough working rule makes the pulse pressure one-quarter to one-third of the systolic pressure; but this is obviously inaccurate, since the normal diastolic pressure never exceeds 100 mm. of mercury and an application of the above ratios to figures of systolic arterial blood pressure approaching the upper limits of normality would prove their error. It must be borne in mind that the arterial blood pressure may vary considerably under the influence of strictly physiologic forces.

The importance of the determination of the two phases of arterial blood pressure, rather than either one to the exclusion of the other, becomes apparent when their meanings are evaluated clinically. Roughly the systolic blood pressure indicates the strain to which an artery is subjected on the systole of the left ventricle; but the

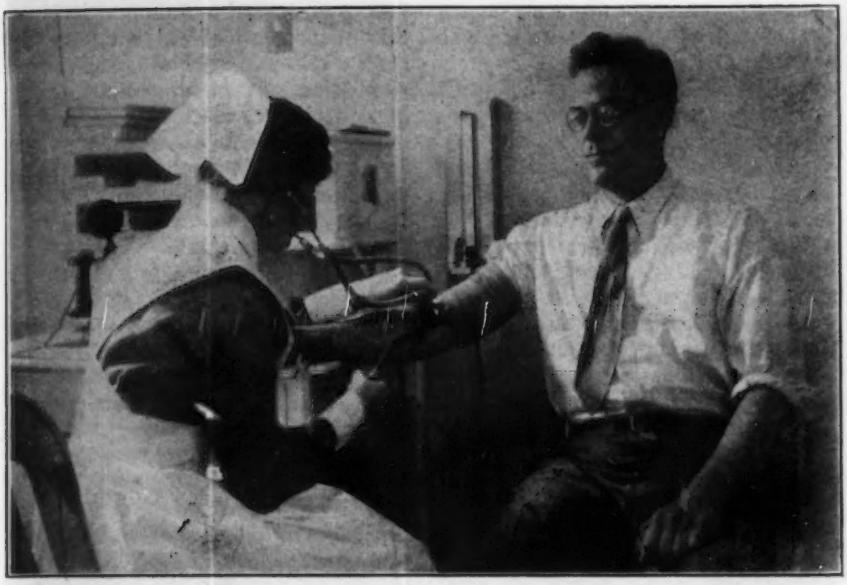

FIGURE II.—The auscultatory method of determining the blood pressure of a patient in sitting posture. In the out-patient department the apparatus is attached to the wall at a convenient height where the figures may be easily read

diastolic pressure is the real index of the maintained load of the heart. With advancing years the systolic pressure tends to rise; but any figure above 160 mm., regardless of the age, should be deemed pathologic. The rule of 100 mm. plus the age of the subject for the systolic pressure finds more exceptions than applications. To insurance examinations most of the lay interest and information as to "blood pressure" may be traced. The interest of these agencies in arterial hypertension in turn arose from an unqualified acceptance of the belief in the dangerous prognosis for individuals showing such a finding. It is now recognized that arterial hypertension, even of the so-called idiopathic or essential type, is merely a sign of some more fundamental process. Indeed many of the subjects with such a manifestation survive their underlying conditions, as Bright's disease, and maintain relatively normal activity, frequently, simply through the compensatory mechanism of an arterial hypertension. Furthermore, it should be emphasized that elevations of the diastolic pressure above 100 mm. of mercury are far more important as measurements of increased circulatory load than are systolic pressures proportionally elevated above 160 mm. In neither case is a diagnosis or a prognosis permissible on this information alone.

A systolic blood pressure in an adult male falling below 100 mm. of mercury constitutes arterial hypotension. Just as in instances of hypertension, the cause may be obscure and these cases are termed essential hypotension. In a better understood relation

arterial hypotension forms an important detail of the clinical syndrome termed Addison's disease, wherein systolic blood pressures of below 80 mm. of mercury may be recorded continuously for many months.

In two valvular diseases of the heart, characteristic changes in the blood pressure are remarked. In aortic regurgitation there appears a disproportionately low diastolic pressure with or without an elevated systolic pressure. The inordinately high pulse pressure resultant from this situation constitutes one of the characteristic findings of aortic regurgitation, although it is also noted in Graves' disease. Interestingly, in aortic regurgitation the systolic pressure in the popliteal artery may be 60 to 80 mm. higher than that in the brachial artery, as compared with the normal difference of 20–30 mm. Then, in aortic stenosis a remarkably low pulse pressure is found. In this instance an actual obstruction to the outflow of blood occurs and rarely does the pulse pressure exceed 25 mm. A failing myocardium not infrequently manifests itself in a falling blood pressure; but peripheral resistance being maintained in decompensation the diastolic and even the systolic pressure may remain elevated until exitus. In an especial relation the determination of the blood pressure must be borne in mind in cardiac affections. The differentiation between angina pectoris and coronary occlusion constitutes a serious problem at times. One point of distinction exists between the blood pressure reactions in the two conditions. In angina pectoris there is no change or but a slight elevation of the blood pressure during the painful attack, whereas in coronary occlusion the blood pressure falls acutely in characteristic cases.

Myocardial degeneration may reflect itself in arrhythmia and in turn this disturbance of rhythm may be readily observed in the peripheral circulation. On blood pressure study in auricular fibrillation there is frequently observed a marked inequality in the time and the tone of the escaping pulses beneath the cuff. To this auditory phenomenon is applied the term, tonal arrhythmia. So irregular may be the appearance of the succeeding systoles, varying in force up to 30 or more mm. of mercury, that as a working rule the level of the appearance of the strongest systoles alone is recorded. As to the diastolic pressure in auricular fibrillation no accurate auscultatory determination can be made. Other arrhythmias may be detected by sphygmomanometry, but time does not admit of further development of this phase of the subject except to mention the very characteristic blood pressure observations in pulsus alternans, or alternation of the heart. In this grave myocardial defect a feeble beat succeeds each stronger systole; so that, as the blood pressure is taken, at the highest level at which systoles escape, or when the first clear sounds appear, only one-half the noted pulse rate is observed. Lowering the pressure in the cuff gradually, a point is reached at which the rate is suddenly doubled. This finding conclusively fixes the disturbance as a pulsus alternans.

From a nursing standpoint probably far more important than the purely medical problems of sphygmomanometry will be its obstetrical and surgical applications. Close observation of the blood pressure during the period of gestation is a routine in the prenatal care of mothers. Where eclampsia is threatened, the frequent registration of the blood pressure serves as one of the most valuable prognostic signs. In the field of surgery probably

the most general utility of this study will be found in anesthesia. No general anesthetic should be given without its control. Not only does a sudden fall in the blood pressure warn the anesthetist and the surgeon of impending collapse, but also in several details its trend is a valuable guide to the stage and state of anesthesia. Shock has for one of its conspicuous signs a falling blood pressure. Hence it is the practice of progressive surgeons, not only to follow the blood pressure curve of their traumatic cases and those in whom blood loss is recognized, but also the blood pressure of all individuals coming to operation while under anesthesia and for a safe period thereafter. Graphic charts of the blood pressure trend are made by the nurse, in conjunction with the pulse curve; and at a glance the attending man may picture this important phase of his patient's condition. From a physiologic standpoint it is important to bear in mind that a systolic blood pressure acutely depressed to 80 mm. of mercury or below for more than two hours cannot be restored to a normal level and there maintained by any known means. Accordingly during the World War among workers in this field such individuals were said to be physiologically dead although anatomically still living. To a special phase of spinal anesthesia one comment should be directed. Here again the course of the patient may be carefully checked by blood pressure studies. In preference to awaiting the development of lowered blood pressure, prophylactic measures have been introduced, important among which has been the use of ephedrine.

Mention has been made earlier of the necessity for frequent blood pressure determinations in injuries to the head. With increased intracranial pressure there steadily develops an increase in blood pressure. Hence in individuals receiving a trauma to the head and in all comatose patients whose background is uncertain, the tendency of the blood pressure must be followed carefully by frequent determinations. The early diagnosis of an intracranial accident may depend upon this finding. Later with the failure of the medullary centers, the blood pressure which has been mounting steadily with increasing intracranial pressure, may fall sharply.

In this brief survey it has been attempted to elucidate the true significance of arterial blood pressure. The technic of its determination has been discussed. The pathologic physiology leading to its alterations, has been briefly outlined. The clinical applications of blood pressure studies involve a limited but well defined and important group of conditions. In this particular field a nurse's intelligent coöperation is no less applicable than in the study of the pulse or the respiration. A standardized technic has merely extended the nurse's usefulness.

The Care of the Sick in Almshouses

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IT is rather shocking just at a time when we are beginning to take pride in the fact that we are extending nursing service to reach all groups—the rich, the middle class, and the poor—to find within the last group—the poor—one whole stratum which nursing scarcely touches at all. These are the indigent old, the aged, infirm, and chronically sick who make up the population of the almshouses of this country.

It is not particularly helpful at this point to say that there should be no almshouses, or that the present development of social consciousness is doing away with the classes who once inhabited the almshouses. These institutions are with us and probably will continue to be for some time to come. True, with the development of social service, with mothers' pensions, workmen's compensation, and other forms of out-door relief, the almshouse population has changed and many of those who might have been its inmates under the conditions of former years have instead been able to achieve independence. However, there still remain those, old and broken, who did not in their youth have the help of social service as we now know it, and who, unable to help themselves, must remain a charge on the community for some time to come. As the Woman's Department of the National Civic Federation reports, following a study of the almshouses of four states:

> The almshouse as such has had little share in a quickened social conscience, and it remains a social backwater. It is only natural that in a movement directed toward construction and rehabilitation the almshouse and its inmates play little part, because it is not a field for constructive or even regenerative work. Nevertheless, it is a social problem and, in some form, an absolute necessity. Intelligently organized outdoor relief would minimize the problem; specialized institutions for the care and treatment of certain pathological conditions would divert phases of it into other channels; but there will inevitably remain an element which, while not requiring specialized treatment, must have some sort of custodial care. State old age pensions would not alter this aspect of indigency because of the patent incapacity of that element for meeting its own needs.[1]

Physical Condition of Almshouse Inmates

SOME of us no doubt have thought of those living in almshouses as peaceful old men and women, not very active physically, but able to help themselves, glad to rest in the sun and dream of old times during the last lingering years of life. Or we have thought of them as the physically strong, though "constitutionally" lazy, who preferred existence on the county farm to a more independent and busy life elsewhere. Or we have not thought much about them at all. Certainly we have not thought of them as a special group needing nursing care.

Of the 10,072 inmates in almshouses in New York state in 1928, 6,291 were sick or infirm; 3,886 were over 70 years old; and 4,779 were between 50 and 70 years old.[2] The State Charities Aid Association of New York in the same year found through visiting 27 almshouses in that state that 20 per cent of the inmates were in need of nursing care, over one-fourth of them being bed cases.[3] During 1929, the State Charities Aid Association Almshouse

[1] *Some American Almshouses.* Woman's Department, The National Civic Federation, 9 East 40th St., New York, 1927, pp. 6–7.

[2] Sixty-second Annual Report of the State Board of Charities, New York, p. 232.

[3] 1928 Report of the State Charities Aid Association to the State Department of Charities.

Visiting Committee found that in 24 almshouses 62 per cent of the inmates were over 65 years old, while in 23 of these 30 per cent of the population were in need of nursing care. It may be assumed also that this last figure would be somewhat increased if adequate medical records had been kept and medical examinations made regularly in these homes, which the committee found not to be the case.

Types of Cases in Almshouses Which Need Nursing Care

THE care of the sick in almshouses is essentially the care of the chronically ill patient. The "chronic" today is unpopular in hospital and public health nursing organizations. The prevention of illness and the supervision of health have become our interests to such an extent that the incurably ill patient has begun to lose our interest. As soon as a hospital patient is known to be a "chronic" he is sent away as fast as possible, for modern hospital development has been almost entirely directed toward the care of acutely ill patients. This development has failed to consider the chronically ill patient and the two types of cases cannot be cared for efficiently and economically in the same institution. Visiting nurse associations in some instances refuse to "carry chronics." And so the last resort of the chronically sick poor is coming to be the almshouse, where, for the most part, nursing and medical service is woefully inadequate.

In 23 almshouses in New York state the types of cases needing nursing care were found by the Almshouse Visiting Committee of the State Charities Aid Association to be as follows:[4]

	Bed Cases		Not Bed Cases	
	Men	Women	Men	Women
Tuberculosis	3	1	8	1
Pneumonia and bronchitis	1	3	3	1
Cancer	6	5	7	5
Heart disease	34	17	68	27
Paralysis	28	22	74	31
Rheumatism	18	5	119	27
Crippled from other causes	1			2
Nephritis	2	1	9	8
Venereal disease	3	1	25	7
Accident		1	4	
Maternity				3
Stomach		1		
Gangrene		2		
Rickets	1			
Infirmities of age		3		1
Idiot	1			
Undiagnosed	2			
Totals	100	62	317	113

Bed cases ..... 162 Not bed cases 430

Among the non-bed cases were many who needed bedside nursing at

[4] 1928 Report of the State Charities Aid Association to the State Department of Charities.

intervals, but who were up and about at the time the visits were made. The Committee also felt that the numbers were less during the summer when the visits were made than they would have been in winter when from 50 to 100 per cent of the almshouse population would be found to be suffering from rheumatism.

In another state (Virginia) it is reported that:

> The population of the average almshouse is composed of the aged and infirm, the afflicted, the feebleminded, idiots, the blind, prostitutes and children of all ages. For instance, our agent's report of one county almshouse, which is incidentally one of the best, showed 16 old and infirm, 3 idiots, 1 feebleminded, 2 prostitutes, 4 physically afflicted, and 7 children, ranging from a few months to 16 years of age.[5]

And in North Carolina, of the total number of inmates, more than 400 are reported sick. Paralysis, tuberculosis, gonorrhoea and cancer are among the more serious ailments.[6]

Adequacy of Nursing Care

WHILE many well and humanely run homes may be found, the reports of the care of the sick in many almshouses give such a picture of neglect, indifference, and poor management through ignorance as to be almost mediaeval in its outlines. Almshouses having space for infirmary service are found to be inadequately equipped and staffed. But worse than this are the many, particularly the many small almshouses, where there is no plan nor provision for the care of the sick and where such care is haphazard and incidental, or entirely lacking.

The Woman's Department of the National Civic Federation reports from its study of the almshouses of four states that the care of the sick in these institutions is "either creditable or appalling." It also goes on to report that:

> Even the best of the hospitalized almshouses are handicapped for want of trained personnel, and often for want of staff adequate to any degree. Trained nurses are few and resident doctors are fewer. Working conditions and salaries for the hospital attendants are not attractive and, in consequence, the turnover is great. Another hindrance seems to lie in the fact that every effort in the way of hospitalization is an experiment in itself, with very little or no correlation with similar attempts. . . .
>
> Where specialized care is not given, the sick for all their greater needs really receive less attention than do the ambulatory inmates who can look after their own needs. Illness in its very nature produces problems of cleanliness and sanitation, and too often the quarters occupied by the sick inmates are drearier, less cared for, and often less clean than the rest of the house.
>
> *The worst feature, however, is the fact that nursing care, the feeding of bed patients, and the many tasks that illness imposes are done after a fashion by other inmates,—nearly always by the mentally defective, because they are the able bodied.*[7]

The State Charities Aid Association reports in 1928 that, even though the majority of the almshouses visited had special infirmary service, the nursing problem was complicated by the fact that the number of beds for the sick was inadequate and many had to be cared for in the general living quarters. In only 3 of the 27 almshouses visited were there trained nurses; in 5 the burden of the nursing care was carried by the superintendent or matron, though in 2 of these a special nurse might be called in when necessary; in 7 inmate labor was used for giving nursing care; while in the rest practical nurses or attendants were depended upon and no information as to the training or experience of these individuals was available.[8]

[5] Virginia. State Board of Charities and Corrections. Thirteenth Annual Report, p. 11.
[6] North Carolina. State Board of Charities and Public Welfare. Biennial Report, 1920–1922, p. 58.
[7] *Some American Almshouses*, pp. 14–15.
[8] 1928 Report of the State Charities Aid Association to the State Department of Charities.

Estelle Stewart in her report on the "Cost of American Almshouses" points out that frequently in the smaller almshouses it is the matron who is responsible for such nursing care as is given, along with the housekeeping duties. This lady usually holds her position by virtue of being the wife of the superintendent and not at all because she is particularly well qualified for the position. That the nursing needs of the sick should go unrecognized or be quite lost among the household duties for which she is responsible is not surprising. In this connection Miss Stewart says:

> The element of inmate care which receives the least attention is that which humanity demands should have the most—the nursing of sick, helpless, old people. The matron has not time to attend properly to nursing the sick, even if she had the knowledge and experience. Nurses are rarely found on the staffs of almshouses of less than one hundred inmates, and where they are it is mostly because of the insane patients in the almshouse. Medical attention is given either by the county physician who makes routine visits, or by a physician who is retained by the county or town officials to respond to call when needed.
>
> Consequently the matron is chiefly, often solely, responsible for the care of inmates in illness, a responsibility which, considering the usual age of the patients, may mean life or death.[9]

To be sure, there are rare and unusual instances of individual matrons accomplishing wonders under great odds. The Woman's Department of the National Civic Federation reports such a matron who is a graduate nurse. This young woman, in spite of the inadequate buildings and public indifference, manages the housekeeping of the almshouse with no help except that of a feebleminded inmate. She does all the cooking, cans fruit and vegetables for inmate use, and nurses two difficult paralytic cases, one of whom is incontinent.[10]

Now not only are such shining examples uncommon, but one wonders why a single individual should have to take on the whole of a burden which so manifestly is one for public concern. Here is further evidence of this curious indifference:

> The population on the day of the visit was four, three women and one man. The man and one woman were ambulatory cases, the man a cripple, the woman of very low mentality. The other two women were very old, 84 and 87. Both were bed cases, one crippled with rheumatism, the other absolutely helpless, and dying literally by inches from a complication of organic diseases. Both were incontinent, and the more helpless of the two has to be cleaned and dressed and her bedding renewed day and night.
>
> All of the nursing on the place is done by the matron, who does all of the work connected with the place—all of the laundering of the bedding for the two incontinent bed patients as well as of the clothing for all of them. She does the cooking of the heavy, more than ample meals which are served even to the bedridden old woman. The matron herself is elderly. Since November there have been four deaths in the home, cases which apparently were taken there to die. According to the matron, "They don't live long after they are brought here—this is their last stop."[11]

All institutions are not so fortunate in their matrons. Some have no matron. For instance:

> The air is vitiated to a point that means actual distress to one coming from outdoors, and the odors are nauseating. Uncovered food stands about in unexpected and unlikely places. The inmates themselves are incredibly dirty.
>
> Four sick men were found lying in this squalor, and there was no one whose business it was to look after them in the slightest degree. The superintendent is a woman, who was absent at the time of the visit. It was reported that she is generally absent.[12]

And again from another source:

> In a certain county home in the state, in one room of a two-room cottage, lies an old man

[9] *Cost of American Almshouses*, by Estelle Stewart. Bulletin of the U. S. Bureau of Labor Statistics No. 386, pp. 39–40.

[10] *Some American Almshouses.*
[11] *Ibid.*, p. 68.
[12] *Ibid.*, p. 52.

with cancer of the stomach. There is no matron in this institution and no nurse. The superintendent looks after the 400-acre farm belonging to the county home and a farm of his own. He is at home but little except at night. In the meantime the old man lies there without attention. When a Red Cross nurse visited the home with the idea of instructing some of the inmates in looking after the others she found no one, able to work, with intelligence enough to follow directions. And the old man continues to lie there without attention. The odor that comes from his room is such that it is difficult to approach within twenty yards of the door.[12]

Causes of these Conditions

IT would not be fair to give the impression that these conditions are found in all almshouses. But it is a serious indictment of the "social consciousness" that they are found in any. How is it that they have been permitted to continue? Perhaps these are some of the reasons:

Control of almshouses is entirely local and the conditions within an individual almshouse reflect the degree of social enlightenment reached by the community in which it happens to be. This, of course, is variable. Although yearly inspection of almshouses is made by agents of state boards of charities, for the most part these boards have not power to enforce any recommendations which they may make. Hence conditions stay about as they are from year to year.

The public as a whole is ignorant of the conditions in and the problems of almshouses. The problem of the sick and indigent poor is not so challenging to the imagination as are some other matters of public health and so the administration of the almshouse is left in the hands of political appointees who often have little understanding of the social problems in their charge.

The almshouse population is changing because of the withdrawal of certain groups who are cared for in state hospitals for the insane, the feeble-minded, and the like, or of others who, having been tided over some economic emergency, have been able to become independent. The withdrawal of these groups has left to almshouse care chiefly the aged and infirm, among them many who are suffering from the chronic illnesses of the old. But with this change in population apparently there has been no very general recognition of the problem of how to care for the chronically ill.

[12] North Carolina. State Board of Charities and Public Welfare. Biennial Report, 1920–1922, p. 61.

What Is To Be Done about It?

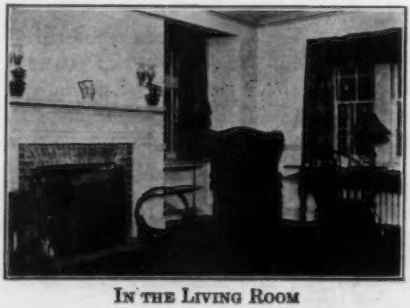
APPARENTLY there are answers to the question, "What is to be done about it?" Much duplication of work, unnecessary expense, and inefficient administration could be saved if there were consolidation of small almshouses into larger, well run institutions under unified management. Again the public must be made to realize that the care of its indigent is as much a responsibility as is any other form of public welfare, and that those in charge must be quite as carefully chosen as any other public officers. Again it must be realized that one of the most important phases of this situation is the need for providing hospital facilities for the many almshouse inmates who are chronically ill.

This problem, the care of the chronically ill and especially of the chronically ill poor, is a nursing problem. Modern nursing, both in England and in this country, was started with the purpose of "cleaning up" just such conditions in hospitals as are still found in almshouses. Furthermore, there is just now a great deal more nursing service available than is being used. Doesn't it seem then that we should do something about it?

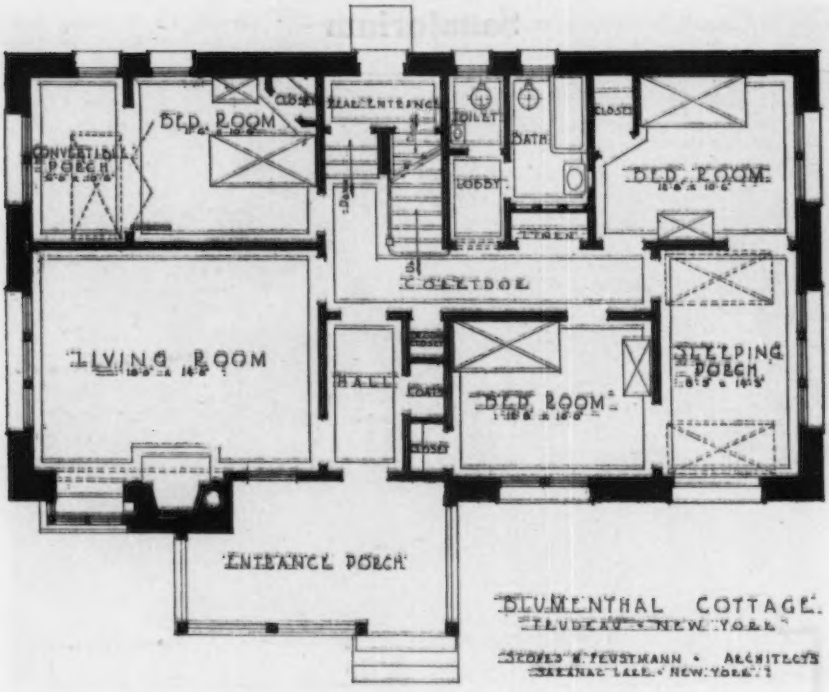
The Blumenthal Cottage for Nurses at Trudeau Sanatorium

"THE LITTLE RED," the first cottage built by Dr. Edward Livingston Trudeau in 1885 at Saranac Lake, N. Y., consisted of one room accommodating two beds. Its porch was so tiny that only one patient could sit out at one time. It cost four hundred dollars, but to the two factory girls who were the first of the long line of patients to be cared for at the now famous institution, it meant life itself. Of the Sanatorium so simply begun Dr. Trudeau, the Beloved Physician, was able to write shortly before his death in 1915:

The Sanatorium has grown to be a picturesque little village. It comprises thirty-six buildings scattered over the entire hillside between the north and south gates, a distance of about three-quarters of a mile. The patients' cottages are grouped about the large administration building, and other cottages for the heads of departments are clustered together at the south entrance, near which are the stables, barns, and the big fireproof laundry. In addition to the patients' cottages, there are many other buildings which represent various activities; a nurses' home for the Training School, an infirmary for bedridden patients, a



IN THE LIVING ROOM



First Floor Plan

post office, a colonial brick and marble library building, a reception and medical building with offices, laboratory and x-ray department, a recreation pavilion for amusements and entertainments, a workshop building where the patients are taught fancy leather work, bookbinding, brass work and frame-making as a recreation and as graded exercise, and a beautiful stone chapel.

Today there are more than fifty buildings and the great work of caring for tuberculosis patients of moderate means goes on. The requirements for admission are clearly stated:

Patients between the ages of sixteen and fifty, who have not had previous sanatorium treatment, who are in the first stages of pulmonary tuberculosis, and free from serious complications are eligible for admission, provided they give satisfactory evidence of limited means.

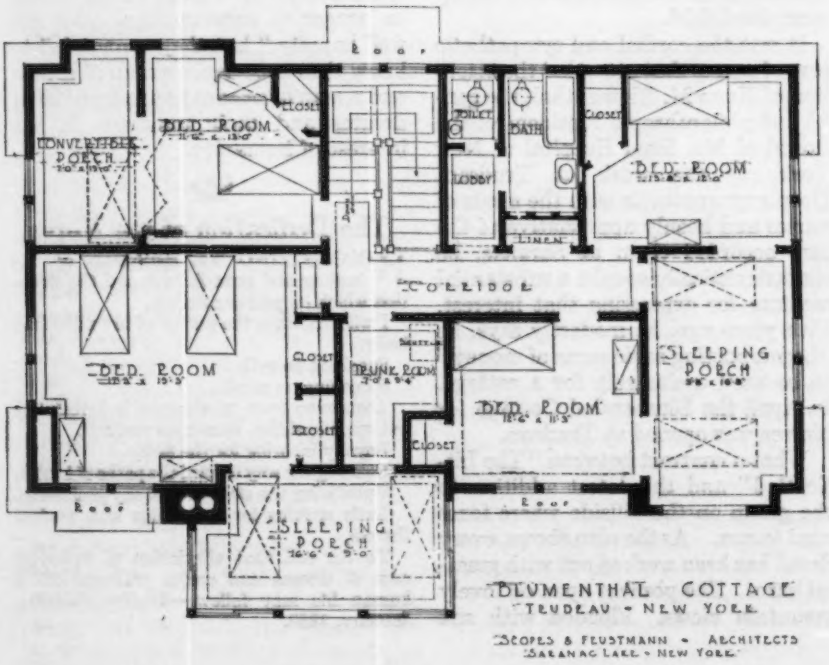
In the report for 1929 we note that

an outstanding immediate need of the Sanatorium is additional support for the Free Bed Fund. . . . The need appears to be particularly urgent in the care of trained nurses who in many instances find themselves without resources to meet the problem of a prolonged course of treatment.

Many nurses have been restored to health and usefulness at Saranac. As this is written, nineteen nurses are under care in the Sanatorium.

One of the interesting features of the Sanatorium is the D. Ogden Mills School of Nursing, the prime purpose of which is to make possible for young women with arrested tuberculosis a career favorable to their future health. It is a "Special" two-year school, but

AERIAL VIEW, TRUDEAU SANATORIUM (Photograph by W. F. Kollecker, Saranac Lake, N. Y.)



SECOND FLOOR PLAN

This beautifully wrought bronze tablet is both a decoration and a reminder

provision is made for a third year of affiliation which qualifies for the New York State Board examinations those physically able to do the work. Such nurses become exceedingly valuable workers in their important and highly specialized field.

It was the cordial and sympathetic care of nurses that attracted the attention of Hugo M. Blumenthal, the genial and philanthropic President of the Board of Mt. Sinai Hospital of New York, to the work at Trudeau. Deeply sympathetic with the needs of nurses and keenly appreciative of the care accorded them at Saranac, he characteristically sought a substantial medium for expressing that interest. Five years ago, he modestly says, he "began putting aside sums of money" to be used exclusively for a cottage. In April the Blumenthal Cottage for Nurses was opened at Trudeau.

What a contrast between "The Little Red" and this latest addition to the group on the hillside where foxes used to run. As the plan shows, every detail has been worked out with greatest care. The porches open on lovely mountain views. Flooded with sun and air, the building is carefully placed in close proximity to the administration building, for the convenience of the nurses who will be patients.

Trudeau's waiting list is always long. Mr. Blumenthal's gift thus adds to the capacity of an important institution. But it does more than that; it provides congenial surroundings for nurses who require care. The cottage now belongs to the Sanatorium and will be administered under its rules. The beds are not free, but are for those who can pay the very moderate rates of the institution. It is to be used for graduate and student nurses. This is the sole restriction placed upon the gift. Nurses who "cure" under its friendly roof may never see the donor nor catch the kindly gleam which accompanies his statement, "It is intended to be a place where nurses, in congenial surroundings, may get well happily," but they cannot fail to know that once again a man of means and a man of science have pooled their dreams and their resources in the interest of humanity.

The Dedication of the Nurse

RECOGNIZING the sacredness of the healing and remedial art and the devotion which its practice entails,

I will maintain the purity of my mind and body,

Speaking no evil,

Spreading no gossip,

Abstaining from whatsoever is harmful to patient, physician, associates and self,

Loyally laboring for the sick,

Pointing the way toward the paths of health,

Upbuilding the standards of my profession,

Daily striving for knowledge and wisdom therein,

To the end that alleviation of suffering, cure of disease and useful prolongation of human life may follow.—*Modern Hospital*, January, 1930.

A Window

JESSIE P. WILSON, R.N.

THE editors of the *Journal* have suggested that private duty nurses become articulate. I have read and heard of much discontent among private duty nurses, due to long hours, unpaid time while waiting for cases in slack seasons, inadequate pay, et cetera. I realize all those disadvantages and shall welcome the new regulations that are sure to come—improved conditions for both nurses and patients, group nursing, shorter hours, steady employment, and a salary we can depend upon and budget in the approved fashion.

I want to write a few words from another point of view, nothing new at all but the happy experience of one nurse that may be the experience of many even under the present conditions of private nursing. *We are not all discontented.* As one of the writers in a recent number of the *Journal* says, "Some nurses like bedside nursing." I do, for one, and I know many others who do. I enjoy the intimate contact with my patients. I am intensely interested in human nature and like to study it at close range, and what better opportunity can one have of doing that than in nursing people—men, women, and children—through illness, weakness, helplessness, back through convalescence to health, or sometimes going down with them into the valley of death, making the way a little less hard for them and standing by them till the moment when they enter the world beyond. Then it is our privilege to turn back from that threshold to give what comfort and strength we can to the sorrowing family left behind. And again what joy there is in welcoming a new life, in caring for the exquisite little creature that every new and healthy baby is, and in teaching a new mother how to care for her baby.

I attended a Lenten service recently,[1] in a beautiful little chapel. The morning sun was shining through a lovely stained glass window above the altar. The thought came to me that we could make our lives like that window if we would, and that the life of a nurse was particularly rich in opportunities for the making of such a window. It is because of that thought that I am attempting to write now and to share with others the aspiration toward loveliness and beauty that came to me then.

The window is made up of color, of background, of lights and shadows, and the glory and beauty of the window is the bright light shining through it. That light in our lives is God's love. We may not be conscious of it. We may think we are not religious. But nevertheless our kindliness, gentleness, good temper, and cheerfulness with our patients is a reflection of that light. The lights and shadows in the picture are made up of joys and sorrows, our own or those shared with others, and so made part of our experience. The colors are made up of many ingredients. Those of us in whom the maternal instinct is strong find scope and happy outlet in the care of children and babies. That makes a beautiful color in the window. Then there is the sense of humor. We are blest if we have it and badly off if we wander into nursing without it. There are few things that help more in a convalescent case.

Culture is a word that covers many things. Some of us have very little of it, but it is something that can be

[1] Publication of this article was delayed by the wealth of Convention material.—*Editor.*

acquired if we want it badly enough and are willing to work for it. Without it you cannot make your window really beautiful, and it seems to me almost indispensable in successful private nursing. Professional skill and knowledge are not enough when you deal with human beings in their own home environment. A love of books, a wide range of taste and subject matter, and regular habits of reading help toward culture. Taste and interest can be deliberately cultivated. We can expose ourselves to good music whenever we have a chance. If we have any knowledge of music and can play or sing, so much the better. Then there are museums and art galleries within reach of most of us. If you begin to study a particular subject it is surprising what riches you find. Once I was nursing a boy and, during his convalescence, we both became interested in Italian art. We got scrapbooks and sent for copies of Italian masterpieces from the Perry Picture Company. I began reading about the Italian Renaissance, and my interest since then has taken me to art galleries and opened books to me that I should not have found or looked for before.

There is another source of endless interest both for the nurse and often for her patients, and that is handicrafts of all kinds—art embroideries, knitting, weaving, tatting, crocheting, painting toy furniture. Making anything is interesting. Children love to watch a thing grow even when they are not able to do anything but lie and watch someone else. A little while ago I was taking care of a four-year-old girl at night. I was making a picture on canvas with colored silks, of a cottage and flower garden and a little path. Each night she said, "Will you make your house tonight?" and each morning when she woke she asked, "Will you show me your house?" And during the day she would talk to her mother about the picture. When it was finished and framed, I left it in the room so that she could show it to her mother and daddy and some of her friends. That made a streak of color, for we both enjoyed it.

We can all think of ways of putting lovely colors into our windows. And then there is the background. It cannot be all lights and shadows and beautiful colors. There must always be a background against which the brighter colors stand out and which, woven in among the figures, gives harmony and binds all together. In our lives as nurses this background is made up of weariness and fatigue patiently borne, of going on from a sense of duty when for the time being our inspiration burns low, of kindness and good temper to trying and apparently uninteresting patients. I said "apparently" uninteresting patients because I believe that if we have a genuine interest in people we can find something of interest, some point of contact, in everyone. Just to illustrate that,—I nursed an old farmer of ninety. He had only once been outside his own county, when he was a boy and his mother took him to New York. He had had no education, had never married, had lived with another old man on his lonely farm for many years, and seemed to know nothing of current events. I was on night duty, and as he got better he sat up for an hour or two in the evening before going to bed. I tried various subjects without success until, in speaking of storms, I happened to mention the blizzard of 1888. I was a little child then, but I can still remember the snow tunnel through which the horse-cars went in Brooklyn, and the back yard filled with snow up to the second story windows, and a black cat buried

under it and dug out alive. That woke a responsive spark in my old man, and for several evenings he was happy telling me how he dug his way from the main barn across a meadow, through the drifts, to the cowbarn where the cows, with distended udders, were moaning and waiting to be milked. He lived that blizzard over again and made it real to me, too. Most of the nursing of that old man was background, but there were spots of color here and there, and the blizzard was one of them, even if it was made up of snowdrifts.

To make a beautiful window through which the light can shine, a nurse must keep her body healthy by fresh air, sunshine, exercise and hygiene, her mind fresh and alert by recreation and outside interests, vacations and travel whenever she can manage them, and her spirit pure, courageous, and steadfast by contact with the best that she knows and can reach,—the Light, or the reflection of that Light.

Treatment of Empyema in Children

PATRICK J. MAHONEY, M.D.

ALMOST every year—especially since the work of the Empyema Commission in the World War—a new device has been advocated for the treatment, by closed drainage, of empyema. Not infrequently these advocates of a new method go to extremes and claim that their apparatus is especially fitted for use in the treatment of all cases of empyema. In proof of this last claim one need but recall, or review, the extremes to which advocates of closed methods of drainage went during the post-war period. Doubtless the cause for this widespread modification in treatment was the high incidence of streptococcus empyema in army camps, and the sad lesson learned by early open drainage.

For the past fifteen years the methods of treatment of empyema have been fairly uniform at the Children's Hospital, Boston. Prior to this it had been impressed upon the surgeons that empyema should not be treated as a surgical emergency. It was well known that operations performed in the syn-pneumonic stage were accompanied by a much higher mortality than when a waiting policy was adopted. Distressing symptoms could be relieved by thoracentesis while waiting for the pneumonia to disappear.

As soon as possible after admission all empyemas are now classified into types—according to the causative organism—be it the streptococcus, the staphylococcus, or the pneumococcus. These three types can then be subdivided into two groups each and called "early" or "late," depending on whether or not the syn-pneumonic stage exists.

The pus of each of these types has easily recognizable characteristics. Confirmation or accurate diagnosis is given in a very short time by the bacteriologist.

Discussion of Types and Treatment Used

STREPTOCOCCUS Empyema.—Children with streptococcus empyema are, generally speaking, the sickest. This special type carries with it the highest mortality. The disease is not infrequently a sequel to a severe upper respiratory infection, a bacteriemia, or an influenza pneumonia. In the early stages of this disease operation is absolutely contra-indicated. Every means of supportive treatment should be afforded—forced fluids, food as tolerated, morphin, rest in Fowler's position, thoracentesis as indicated, and good general nursing care are all in order. The temperature and pulse are usually very high. With a low resistance the white count is not infrequently low. By supportive treatment in the course of a few days the temperature and pulse fall, and the white count goes up. The child then does not look as sick, though there still is respiratory embarrassment. We are now in the "late" stage.

It is in this "later" stage, and not until then, that operation is to be considered—most agree that closed drainage is the operative procedure of choice. For this the apparatus described herewith is quite effective.

Staphylococcus Empyema.—This is the rarest of types mentioned and in our experience carries with it the lowest mortality. It is usually a sequel to a long drawn out bronchopneumonia. Operation is to be avoided here in the syn-pneumonic stage, multiple thoracenteses being used to carry on. The fluid is quite characteristic in that it is heavily laden with thick pus cells and but little fibrin. These cases do well with the closed method of drainage later described, there being little tendency to the formation of adhesions which prevent expansion of the lung.

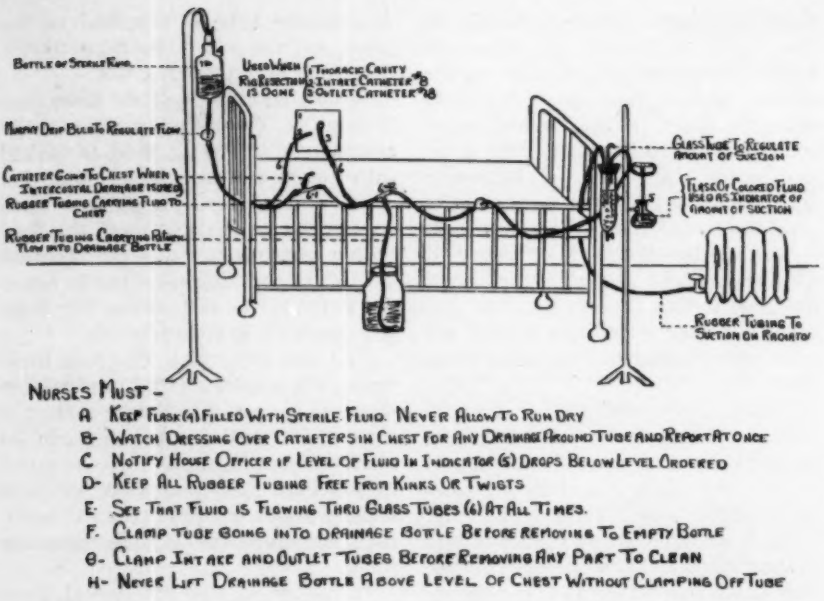
Pneumococcus Empyema.—This is the kind so frequently seen coming on after or as a complication of acute lobar pneumonia. Ordinarily, in children, the diagnosis is not well established by the local doctor until the pneumonia is over—hence there is less chance or danger here of operating in the syn-pneumonic stage.

The aspiration fluid obtained in pneumococcus empyema is quite characteristic. It is a thick greenish yellow, and contains a large amount of fibrin. Should operation be delayed, the fibrin has a tendency to organize to form a thick fibrinoplastic material which forms the basis for adhesions. These adhesions may form in such a way as to hold a lung collapsed. Hence, we can see that often in late pneumococcus empyema, a closed drainage would be inadequate because these adhesions could not be broken up so as to allow the lung to expand.

All are agreed at this hospital that in the late stage a rib resection which permits the freeing of adhesions and the cleaning out of the fibrinopurulent and the plastic exudate is the operation of choice. Should one, however, have reason to believe that adhesions have not formed (*i. e.* relatively early case) and that the fibrin is not plastic, there certainly is no contra-indication but rather an indication for closed drainage.

Closed Drainage

PERHAPS the simplest method of closed drainage is the Mazingo. A catheter is passed to the pleural cavity through a hole made in an intercostal space by a trochar. Air is not allowed to get into the pleural cavity at the time of operation. After operation the tube is led to a drainage


Bottle of Sterile Fluid
Used When Thoracic Cavity Has Resection & Is Done
Intake Catheter #8
Outlet Catheter #18
Hospital Drip Bulb To Regulate Flow
Glass Tube To Regulate Amount of Suction
Catheter Going To Chest When Intercostal Drainage Is Used
Rubber Tubing Carrying Fluid To Chest
Test Tube Of Colored Fluid Used As Indicator of Amount of Suction
Rubber Tubing Carrying Fluid From Chest Into Drainage Bottle
Rubber Tubing To Suction Or Aspirator
Nurses Must -
A Keep Flask (4) Filled With Sterile Fluid. Never Allow To Run Dry
B- Watch Dressing Over Catheters In Chest For Any Drainage Around Tube And Report At Once
C Notify House Officer If Level Of Fluid In Indicator (5) Drops Below Level Ordered
D- Keep All Rubber Tubing Free From Kinks Or Twists
E- See That Fluid Is Flowing Thru Glass Tubes (6) At All Times.
F. Clamp Tube Going Into Drainage Bottle Before Removing To Empty Bottle
G- Clamp Intake And Outlet Tubes Before Removing Any Part To Clean
H- Never Lift Drainage Bottle Above Level Of Chest Without Clamping Off Tube

bottle at the side of the bed. Its distal end is kept under water. Gravity assists in drainage. One disadvantage of this scheme is that of irrigation, during which it is difficult to avoid getting air into the thoracic cavity.

Hart of Baltimore in 1928 and 1929 reported on a series of cases treated with tidal irrigation and suction. A small series of cases (about fifteen) were tried at the Children's Hospital. The results, while no worse than other methods heretofore tried, were not impressive considering the great increase in labor and worry involved. There seemed to be one very great handicap —the suction unit (Connell apparatus).

The Connell apparatus does well—but some one, an intern or graduate nurse, with a mechanical trend of mind and who is interested in the treatment of empyema must be on call and check up on the apparatus at very frequent intervals. The average nurse or student has a certain amount of fear in attempting to manage what seems to her, at first, dozens of tubes and bits of glassware running in every direction; the average intern is really too busy to give it sufficient time. Breakage is another important factor —especially on a children's ward where frequent attentions to the child are required.

In view of these difficulties, an attempt was made here to obtain a simpler type of suction, one that would be reliable, cause no noise, and would work at all times with the minimum amount of nursing attention.

At first we thought of a small electric motor, but these are apt to get out of order and they are noisy. A faucet water pump is not feasible because of hospital construction. Finally it was observed that at the Children's Hospital, as is true in almost any large plant,

there is a suction return system in all the steam radiators. A pump or pumps keeps up this suction at the central power plant at all times in order to assist in the circulation of steam and in freeing the system of air and water. All that was necessary then was to put a fixture to the outlet pipe of any radiator.

The suction obtained, of course, is too strong and variable for direct use, but it can be regulated to any desired pressure by the use of the small bit of apparatus described herewith.

This pressure-regulating device consists of a Salvarsan burette with three glass tubes and a rubber stopper. Two of the tubes, A and C, are short right angle tubes; tube B is long. Tube A is connected by rubber tubing to the radiator. The quantity of suction which is obtained at C is dependent upon the distance tube B is below the water level. For example, if the lower end of tube B is above water level, then air is drawn through tube B with hardly any resistance. As a result of this no suction is noted at tube C outlet. If, on the other hand, tube B is 6 cm. below water level, it will be noted on the manometer, in connection with tube C and the pleural cavity, that there is a negative pressure of 6 cm. of water in the tubes and, therefore, in the pleural cavity.

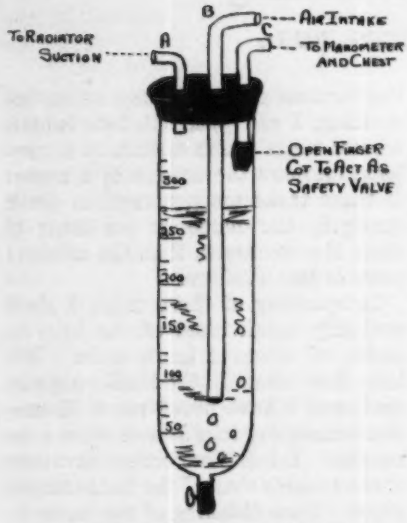
The accompanying diagram will illustrate how the entire apparatus works. Sterile saline or Dakin's flows from a Kelly bottle via a Murphy drip bulb through a tube to a curved T tube No. 6-1, the curved portion of which is attached to a small intercostal rubber catheter drainage tube. Another rubber tube connects the other end of the T tube No. 6-1 with a second T tube No. 6-2 attached to the side of the bed at the same level with T tube No. 6-1. A drainage tube is attached to the lower end; the suction tube to the other end of T tube No. 6-2.

Mechanism: As the fluid flows past T tube No. 6-1 with expansion of the chest wall, irrigating fluid is sucked into the pleural cavity, the lung and chest wall acting as a pump. With contraction of the chest wall the fluid with a certain amount of pus is forced out. The swishing effect can be noted at T tube No. 6-2 where the level changes with each respiration.

The accompanying diagram illustrates the apparatus and outlines the duties of the nurse in charge of the patient. The entire apparatus can be sterilized and assembled by the nurse in less than thirty minutes, which is usually about the time taken in sending a patient to and from the operating room.

In children, the intercostal tube stays in position without leakage for about a week's time. If, when leakage is first noted, the area is cleaned, and fresh adhesive applied so as to draw the soft parts toward the tube, leakage is again prevented for four or five days. By this time, the cavity is practically eliminated, or very small, and irrigations with a small catheter for a short time suffice to obliterate it, and allow healing over of the skin.

Two or three pneumococcus cases have been tried with closed irrigation and suction, following a rib resection for removal of fibrin and the freeing of adhesions. Two catheters in these cases are put in one (No. 8) at the upper pole of the wound and one (No. 18) at the lower pole before closure of incision. Through the No. 8 catheter flows the irrigating fluid; the No. 18 catheter is attached to the suction apparatus. (See diagram.) The incision healed nicely in these cases, and the apparatus stayed without leakage



Pressure-Regulating Device

for about ten days. These patients did very well.

The advantages of this particular type of drainage are:

1. Once set up and working it requires very little adjusting but hourly attention.
2. The patient is not disturbed every four hours or so for irrigations and painful dressings, rather he is being irrigated painlessly every minute of the day and night.
3. Blow bottles are not needed because the suction tends to pull the lung to the chest wall.
4. There is a marked saving on sterile supplies of gauze, cotton, towels, et cetera.
5. All the infectious material is collected in one bottle, the disposal of which is easy. Hence, there is markedly less chance of ward contamination.
6. Its cost is practically nil, considering the "free" suction.
7. The children are comfortable and pleased with the bubbling fluid (usually colored for effect) at the foot of the bed.

Public Health Nursing at Fordham University

A DEPARTMENT of Public Health Nursing has been established in the School of Sociology and Social Service of Fordham University with Ann Doyle, R.N., B.S., as Director. Fordham is the first of the Catholic universities to offer courses in public health nursing. Applicants must be high school graduates, registered nurses, graduates of a school of nursing of recognized standards and eligible for membership in the National Organization for Public Health Nursing.

A certificate in public health nursing will be awarded to students satisfactorily completing instruction and field work totalling 32 credit points. Required subjects are Public Health and Preventive Medicine; Public Health Nursing; Sociology; Social Case Work; Social Resources; Educational Psychology; Methods of Teaching. Interesting electives from courses already well established in the university and a minimum period of eight weeks of field work complete the requirements. Most of the courses are planned for the evening in order to make the work widely available for nurses now employed in or near New York City. An interesting feature of the work is the provision of a special Saturday afternoon class in public health nursing planned especially for directors, instructors and supervisors in schools of nursing. The rich public health facilities of New York City and vicinity will be drawn upon for observation and practice. Under the direction of Miss Doyle, graduate of the Georgetown University Hospital, who holds a diploma in Organization and Supervision in Public Health Nursing from Teachers College, Columbia University, and who is widely known for her work with the U. S. Public Health Service, the success of the new department seems assured.

Personality in Nursing[1]

W. W. CHARTERS, PH.D.

I HAVE been interested in personality, applied to any profession, for a number of years, having had the opportunity to study with some care the personal traits of retail sales people, druggists, life insurance salesmen, teachers, and members of other occupations. I am interested in making such analyses—not so much to find out what traits are most important, but probably to find topics on which to base the development of personality. I for one believe that personality can be developed, not only can be developed but is being developed, all the time. A personality changes with the years. Personality at the age of sixty is not the same that it was at sixteen, or twenty-six, or thirty-six, or forty-six. Changes in personality are the expected and the common occurrences in life.

It is possible to hasten changes in personality. If a person has a trait which is not satisfactory he may in time outgrow it, but it is possible by paying attention to it to change it more rapidly. The change might ordinarily take a lifetime, but sometimes it can be made in six months or a year if one turns oneself to the task intensively.

If I should make a complete analysis of the traits of nurses, I shall probably find in the neighborhood of seventy or eighty. I can telescope these into a list of twenty-five, which is still a large list. We can carry the telescoping a step farther and pick out three, four, or five traits which to my way of thinking are the essential traits of nurses.

As I have observed the nursing profession in action, as the consumer of the services of nurses, and as an instructor, I can pick out four fundamental traits which explain in a very large measure the success of a nurse. If those traits are possessed in great strength, the nurse is excellent; if there is a weakness, then the nurse is more or less a failure.

In speaking of those traits I shall probably speak more of the bedside nurse, of whom I know more. We have had nurses in the family a great deal, and I have heard much discussion among my friends and other consumers. I shall therefore speak rather of the bedside than of the institutional nurse. I am thinking of the nurse in relationship to the patient and to the family, but on some other occasion it might easily be possible for me to make applications to the institutional nurse.

The first trait then that I wish to mention is of primary importance in nursing as in all other vocations—*the trait of dependability*. By that I mean honesty, sincerity, punctuality—all those traits which we think of as making a strong character, a substantial character, a character that one can count upon in emergencies or at any other time. I suppose you will all agree with me in this. If a nurse lacks dependability it is quite clear that on an occasion when a patient may need the nurse very badly she may be somewhere else. If commissions are given by the doctor he cannot depend upon their being completed; in general, nothing can be counted upon. I suppose the trait of dependability is the most important of all traits where people move together in a group. My actions as an individual are dependent upon the actions of people who surround me. I count upon them to do

[1] Read before the Twelfth District, Ohio State Nurses' Association, November 6, 1929.

a certain thing; if they do not do it, then I have to revise my actions.

I recall a department store film which shows what happens when a salesgirl puts the wrong address on a parcel. In this lurid picture we find twenty-eight people who have to do something extra because a girl spelled the avenue incorrectly. That illustrates what I have stated. The doctor says, "Do so-and-so." He goes away thinking it will be done. He arranges his work accordingly, but if he finds that it has not been done he has to do his work over again. No one likes to change his plans, and in the nurse's occupation such lack of dependability frequently results in disaster.

The trait of dependability, then, is more or less taken for granted in the good nurse. I think there is no trait whose absence is more important in keeping nurses out of positions. If a nurse cannot be counted upon she may be employed once but she will not be employed again by those who know her. Everywhere in the world we want people to stay put. When assigned to do a thing, they are expected to do it, and failure to do it is very severely penalized in all professions. The erratic individual is not welcome anywhere.

Dependability, then, is the basic trait upon which the profession rests.

The second trait which I shall mention is a very interesting one. I call it *friendliness*. I have seen many nurses in our own home, perhaps a dozen or fifteen. We have been married a long while and have a family of four children. When one was not sick the other was, sometimes all sick together. After reviewing this long list of nurses, and after listening to the conversation of other people, I have come to the conclusion that the friendly sympathetic nurse in the family is the one whom we like to have, whom we remember, and who in some cases has become a long-term friend of the family. Our family has two or three nurse friends now with whom we have been intimate for ten or fifteen years. We take them as members of the family so that from time to time they visit as house guests. As I see it, these particular nurses were typical of the high type referred to. They were absolutely dependable, felt a liking for the family, and so engendered a mutual regard.

To be friendly, it is not necessary to make intimate friends of everybody. I am not thinking of intimacy, but of that trait which enables us to like people in general.

There are people who would stand before a group like this, look over the faces, and think of all that is wrong with them. They would think that there was no one person they would care much for. They have a negative attitude. Other people standing before a group like this would take for granted that there were many fine people in the group and that everybody was nice to some extent. That expresses the attitude of friendliness.

Friendliness toward people is entirely a matter of the personal point of view of the individual; it does not reside in other people. If my attitude toward people is unfriendly, it is not the fault of the people, it is my fault, because in the main, by and large, people are more good than bad. People mean well more than they mean badly. If I am in a community for a year and in that time have grown to dislike the people completely, I may rest assured that the fault is mine, not the community's. It does not matter where the community is, there are likable people always to be found. Friendliness, then, is completely within the control of the individual.

There are even possibilities that a person, just by saying he is going to like people and by performing different devices necessary to develop that trait, can change his whole attitude toward acquaintances and associates.

I have seen this done over and over again. As a matter of fact, the simple method of developing friendliness toward people can be summed up in a nutshell. All that one has to do to develop a friendly attitude toward people is to think about and recount their good points. If one wishes to be unfriendly toward people, what he does is to think of all their bad points. In fact, I have a test that I sometimes give; it is called an association test. As soon as I announce a name, think of the first thing that pops into your head about that person. Take your last patient. What was your first thought? Was it friendly or unfriendly? Was it of some fault, or some good quality? Think of your last doctor. Think of your younger brother. Think of your roommate. My point is this. If, when names come up, you first recall something you do not like about their owner, you can be sure that you are very critical of people, and not friendly. The first thing that pops into your head is the essence of what you think of people. If the first thing is always critical, then you are critical; and if critical, you are unfriendly.

I am not one who believes we should all be pollyannas. I should not like to live in a world where people thought only good of others. Most people have more good points than bad points, and if therefore people remember the good points they are kind rather than critical. We are allowed, of course, to see a man's faults, but they balance in the majority of cases; that is to say, the balance is on the good side. Of course, everybody is allowed in this world to have a few "pet peeves." I am talking about the first contacts which we make with people. If our attitude toward people is that of seeing the good points, that makes for friendliness. In fact, that is the way to make friends. Try it out on yourself. If you want to take a little exercise in developing friendliness, select your "pet peeve," and instead of cataloguing all his faults, which you think are legion, try to think of his good points.

To develop the trait of friendliness is a very simple thing. It merely consists in thinking of the good points of people, rather than their bad points. It is surprising what people can accomplish who are friendly disposed, and we assume most are. It makes a nice world to live in. I should hate to be extremely critical of everybody. Think of the people I would have to live with. They would be selfish, ambitious, ugly. I would have to move among these people all my life. I think I should then commit suicide. On the other hand, with this same group we can make an entirely different environment. We can say, "This woman is bad and selfish, but she is a very hard worker." "This one is not very handsome, but she is certainly dependable, and we can count on her before anybody else." "This one, while she has not very good taste, is friendly and unselfish." By just such slight change in one's own attitude the complexion of the whole world may be altered.

The third trait of importance, in addition to dependability, or strength of character, and the trait of friendliness just mentioned, I call the trait of *intelligence*. By that I mean brightness, thoughtfulness, ability to think of things, not merely to follow a routine. Intelligence is the kind of thing which enables a nurse when

going into a home to handle the situation. She understands the right thing to do. She does not have to work by rule of thumb. She must be able to follow the doctor's orders, but when the doctor's orders do not cover the case, she is bright enough to think of the things to be done. The "dumb" nurse, the nurse who is not intelligent in this respect and not keen, is not likely to be so useful to the family or to the doctor as the nurse who has some ideas of her own.

I know I am walking on dangerous ground. There are some doctors who think nurses are not very intelligent, and say to the nurse: "You do exactly what you are told, and do not do anything else." I have heard of such doctors. I never saw one myself, but the type is clear enough. Such a doctor will not allow the nurse to have any initiative in any way. Perhaps you are taught that in your schools. You must obey implicitly. Yet you can obey the doctor's orders implicitly, and still have use for your intelligence —intelligence in meeting situations which he has not described.

The fourth quality is one which for want of a better term we might call *leadership*. I mean by that, ability to manage. When one gets sick and wants a doctor, in nine cases out of ten the chief advantage in having the doctor is to secure assurance. He has practical leadership. He says the baby is not so sick, he gives some pills, or directs that the window be raised. But when he has gone one's whole attitude toward the illness is completely changed.

It is the most wonderful thing in the world for a nurse to come into a family, where some member is seriously ill, and take charge of things. That does not mean that she washes the dishes, carries the coal, and the like. Such things are manual labor. I mean that she has the ability to size up the situation, smooth things out, so that affairs will be running quietly and easily; sometimes delegating work to others; sometimes telling the mother what to do, sometimes doing little things herself. In other words she takes hold of the chaotic situation and runs things more smoothly perhaps than the housewife herself had been able to run them. Such a nurse is worth her weight in gold. In many cases it does not involve a huge amount of work. It means the using of one's brain and managerial ability to get things running smoothly. Some people are born good managers, but most people have to achieve it. It is a thing that can be achieved by a very simple process.

A manager is one who is able to detach himself from a situation and see what needs to be done in an orderly sort of way. She is one who can say, "We must do this and this, have a good breakfast and get father off. The next thing to do is so and so." In other words, the good manager will lay out a plan, and proceed in an orderly way to carry it out.

There is one type of person that does this better than any other. The type that does it the best is the lazy type. The type that does not do it so well is the motor type. The motor type person when she gets into action says, "Let's go!" This type must do something immediately. The lazy person does not like to work, or to do too many things, so he stands back and looks at the situation to see what is the easiest way to get things running. The lazy man is the inventor, the planner. The reason why there are not so many inventions in the kitchen is because the men are not in the kitchen, and women are not so lazy as men. The man figures how to

do things more easily. Waterworks were established by man because he did not want to carry water up from the creek. Wagons were invented by man because he did not want to carry loads; woman would have kept on carrying them. Tables were invented by man to hold up the food so that he would not have to get down on the floor. Hammers were invented because stones hurt his hands. So, we might run through the whole category of inventions made by the lazy man. But it is the lazy man with ambition. There is a type of lazy man who won't make a move in any direction. Inventions never are made by men who want something badly, but who are still lazy. They must want them badly. If they do not want them badly enough to invent something they are pure lazy. The combination of laziness and ambition makes the inventor.

So with the manager. He does not like to do more than he has to, and so he sits back and figures on how to do it in the easiest way. People who are of the motor type have a hard time of it in planning because it is so hard for them not to be doing something. I have seen some people for whom it was harder not to work than it was for me, frankly a lazy man, to exert myself. The motor type will simply act; they cannot wait. The manager will say: "Wait a minute before starting. Let's see what is the best way to do this." He puts the brakes on; exercises will power. He will stand back and look at the job before starting, and perhaps then will find some short method never observed before.

I have mentioned, therefore, four fundamental qualities: the quality of dependability—sincerity, honesty, conscientiousness; the quality of friendliness—sympathy, kindliness, good will toward the patient and the doctor; intelligence—resourcefulness in thinking and inventing bright ways of doing things; and leadership, or managerial ability which enables one to take hold of a situation and smooth it out so that it will be handled without difficulty and friction.

Any nurse who possesses these four qualities to a high degree is, to my way of thinking, a very excellent nurse. I shall not say a perfect nurse because there are other qualities which go to make the perfect nurse. But if a nurse is lacking in these four qualities she will not make a complete success. If she lacks dependability one does not want to have her around; if she is wanting in friendliness, one does not like to have her around even though she has dependability. It is not so serious if she is lacking in intelligence, because after all her work may be pretty well routinized. If we have a faithful, conscientious and dependable nurse who is friendly and kind, it does not matter quite so much if she is not an Isaac Newton, or an Einstein. I would say, therefore, that initiative and intelligence are not quite so important as the other qualities. In many crucial cases lack of managerial ability might be very bad, but in other cases it might not be so important. So we come back to two fundamental qualities: dependability and friendliness. If present, they produce success; if absent, make for failure.

Nursing in Plastic Surgery

MARION CRISSMAN, R.N.

PLASTIC SURGERY deals with the repair of defects and malformations, with the restoration of function and the improvement of appearance.

As no two cases of plastic surgery are alike, the nursing care cannot be governed by any routine. The nurse must understand what the surgeon is endeavoring to accomplish. Results are sometimes very slow, and in these cases the building up of the general condition, the mental outlook, and the routine care of the patient present as many problems as the operation itself.

Treatment on Admission

PATIENTS admitted to our hospital with hemoglobin under 75 per cent are put under supervision. Special attention is given to the diet. Alpine light treatments beginning at one minute and increasing one minute every day up to fifteen minutes are useful.

If necessary, blood transfusions may be given. Blood clotting time is taken, and if this is over five minutes the patient is given calcium lactate for several days. No operation is performed until the surgeon is sure that the physical condition of the patient is satisfactory.

Infection plays an important part both before and after the operation. Patients may have an infection when admitted to the hospital, or infection may develop following the operation. The tub is often used to combat infection.

If the area to be treated is large, the entire body is placed in a tub of water at 98 degrees F. While in the tub, the necrotic tissue is removed and the suppurating areas are gently cleansed with sterile cotton. The frequency and duration of this treatment are regulated by the condition of the patient. The usual order for cleansing purposes is fifteen minutes, twice a day, but frequently the patient is allowed to remain in the tub for several hours at a time.

Sterile linen is used on the bed. Constant heat at a temperature of 98 degrees is applied by means of a cradle made of non-inflammable fibre equipped with electric light bulbs. This also prevents the sagging of the bed clothes. The heat is checked by means of a thermometer hanging on the cradle; if too hot, the necessary bulbs are turned off and vice versa.

If the area is restricted to an extremity, the local continuous tub may be used. Compresses saturated with Dakin's solution, hexylresorcinol S.T. 37, normal salt solution, boric solution, and antiseptics in varying strengths, are frequently used on smaller areas.

Anesthesia

THE type of anesthetic used in plastic surgery depends upon the patient and the operation. Small deep grafts and minor operations are performed under a local anesthetic, adrenalin 6 to 10 drops to 1 ounce of novocain ½ per cent being used. Nitrous oxid and oxygen, colonic ether, or avertin, alone or in combinations, are given for more extensive operations. The two latter anesthetics are administered on the ward by the nurses under the doctor's orders. Colonic irrigations of tap water 1,000 cc. are always given following operations performed under ether given per rectum.

Skin Grafts

PLASTIC SURGERY includes the transfer of tissue from one part of the body to another. Skin grafting is very important in this type of surgery. The type of graft, general condition of the patient, the extent of the operation, and the site of the operation, are the main factors governing the nursing care.

All types of grafts may be placed on fresh wounds and also on healthy granulating surfaces. . . . When placed on granulating surfaces success depends to a large extent on the condition of the wound, and it is most important that the granulations be clean, firm, rose-pink in color and not exuberant.[1]

Small deep grafts, cut to include a considerable thickness of the true skin, are used to hasten the healing of granulating wounds. As a large number of these grafts can be obtained from a comparatively small area it is possible to use them on extensive wounds.

These grafts are obtained by picking up a bit of the epidermis with a straight intestinal needle held in an artery clamp. It is raised so that a little cone is formed and the base of the cone is cut through by depressing the blade of the knife. The graft, still on the needle, is transferred to the wound with the raw surface downward.[2]

Forty-eight hours before an operation for small deep grafts, the area to be grafted is compressed with saturated solution of boric or normal salt solution at 98 degrees F. Following the placing of the grafts, a dressing of perforated protective and sterile sea sponge is applied. The area supplying the grafts is covered with silver foil and xeroform gauze. The first dressing is done forty-eight hours after operation. The grafted area is cleansed with boric solution on cotton pledgets and, if the grafts are in good condition, a dressing similar to the original dressing is applied. If the granulations between the grafts pile up and prevent the spread of epithelium, a dressing of bismuth gauze saturated with pure sterile glycerin is useful. This dressing is moistened every three hours with glycerin. As new epithelium fills the spaces between the grafts and meets the wound edges, the grafted area may be exposed to the air. The area from which the grafts are obtained is treated as any surgical wound, the first dressing being delayed for ten days.

The length of time the patient remains in bed depends upon the size and location of the area. The grafted area should be protected from pressure or injury for about three weeks, after which time gentle massage with cocoa butter should be given, and continued until the grafted area is as freely movable as the normal skin.

Ollier-Thiersch grafts are usually cut from the thigh; occasionally the skin from the arm or leg is used. "The graft should be cut at a level which will include the top of the papillary layer of the corium." These grafts are much larger and much thinner than small deep grafts, and the cosmetic results are more satisfactory. They are contraindicated on account of their thinness where the grafted area is exposed to constant trauma. A dressing of silver foil and sterile rubber protective is placed over the area from which the graft is taken. The superficial wound usually heals promptly and before the patient is ready to leave the hospital. The raw surface of the graft is placed next to the wound. A dressing of silver foil, xeroform gauze and sea sponge held snugly with adhesive plaster and a bandage are placed over the grafted area and the part immobilized. The dressings are done by the surgeon, the first dressing, if the grafts are placed

[1] Davis, *Plastic Surgery*, p. 52.
[2] *Ibid.*, p, 56.

on a clean wound, being delayed at least seven days.

The nursing care depends upon the portion of the body to which the graft has been transferred.

The whole thickness graft (*Wolfe-Krause*) is used in situations where there is a good deal of trauma and friction, as the elbow, palm of the hand, knee, or heel. These grafts are usually taken from the tissues where there is sufficient laxity to permit the edges of the wound to be sutured, for instance, the upper arm and the thigh. The type of skin of the area to be grafted must be considered in choosing the skin to cover it.

The whole thickness graft, which includes the epidermis and the full thickness of the corium is marked out and is removed under aseptic technic. The area from which the graft is taken is immediately sutured, and a dressing

FIGURE I.—Two days after the application of small deep grafts to a defect made by excising a chronic ulcer

FIGURE II.—The same area eighteen months later. Note the individual grafts and the type of healing which is permanent

of silver foil and xeroform gauze applied. The area to be grafted is prepared and the graft is immediately sutured into place. A dressing of silver foil and xeroform gauze is applied, a pressure bag placed over this and held snugly by a bandage and adhesive plaster. The amount of pressure in the bag depends upon the type of graft, 30 mm. of mercury pressure ordinarily being used. A sterile sea sponge, over the silver foil and the xeroform gauze, applied under even pressure is also an excellent dressing for whole thickness grafts. The first dressing is usually done after about a week or ten days, but sooner if contamination has occurred.

The nursing care is that given to any bed patient. Dressings are performed by the surgeon. If the graft is on an extremity, the part is kept elevated on pillows.

After several weeks, massage of the

FIGURE III.—Four days after the transfer of a tubed flap previously formed on the arm, to fill a cheek defect. Note the position of the arm; the tubed pedicle carrying the circulation to the opened out portion of the flap until the new blood supply from the face is established; the stump of the lower pedicle which was divided before the tube was opened; the horsehair stitches holding the flap in position. The upper pedicle was divided after twelve days and the ends were set into cheek and arm respectively

grafted area and surrounding tissues may be started. This is continued until the area is as freely movable as the tissues surrounding it.

The pedunculated flap of skin and subcutaneous tissue is another type of tissue transfer used in plastic surgery. It is used particularly where the skin and subcutaneous tissue have been destroyed. The process is slow as the operation is divided into several stages. Flaps may be taken from the tissues in the neighborhood, or from a distant point. If taken from a distant point, the procedure is trying for the patient, as immobilization and enforced position of the part, as for instance the arm to the face, may be very irksome.

In such a case, in the delayed transfer type, the flap is raised from its bed but is left attached at each end. The skin beneath the flap is closed and a dressing of vaselined gauze is placed between the flap and the skin. The blood supply is established in the flap before the pedicle is cut, which usually requires ten to fourteen days. Sterile compresses of normal salt solution at 98 degrees F. are applied constantly after operation and are continued until the flap shows that good circulation is established. During this period the patient may assume the orders of an ambulatory patient. When the blood supply has been fully established, one pedicle is cut, the area to be grafted is prepared, and the free end of the flap is attached. The arm is immobilized so that no tension will be put on the flap. A plaster cast may be applied, or the part may be held in position with strips of adhesive tape and a bandage. The position of the arm must be watched closely. Massage and frequent adjustment of position are necessary for the comfort of the patient. The Gatch bed is ideal for these patients as their position can be changed frequently without disturbing the position of the arm. Normal salt compresses at 98 degrees F. are usually ordered for the flap, and these compresses require constant and vigilant supervision. They must be changed every fifteen minutes, so that an even temperature is maintained. Pressure must be avoided in applying them, but every portion of the flap must be in contact with the wet compress. Change of color in the flap or around the suture line, tension on the sutures, collection of serum or beginning infection are things the nurse must notice and report immediately. The failure

to do so may mean the loss of the entire flap.

The diet must be watched carefully so that the patient will have as little nausea as possible. Diet is increased as rapidly as may be desired, but in work about the face, care must be taken to exclude foods requiring much mastication. The mouth and eyes must be kept cleansed.

Circulation should be established between the face and the flap before the pedicle is divided, usually twelve to fourteen days. The amputation is usually performed in stages to avoid cutting off the circulation at one time. After the pedicle has been severed it is immediately fitted to its proper place, and the stump of the pedicle is returned to its original bed.

FIGURE IV.—Congenital bilateral incomplete prealveolar cleft of the lip

Importance of Subjective Symptoms

IN all cases of plastic surgery it is important for the nurse to be guided by the patient in making her report to the surgeon. It is particularly important that she pay attention to any complaint of pain in the operative region; in cases of skin and tissue transfer this means the area from which the graft is taken, pressure of the dressings, and uncomfortable or too tight bandgages. The immediate relief may mean the saving of the graft and preventing the spread of infection, as well as giving mental and physical relief to the patient.

FIGURE V.—Same patient ten days after operation. Note the fresh scar and the stitch marks, which can still be seen

Harelip and Cleft Palate

THE nursing care in cases of harelip and cleft palate is extremely important. The age for operation is usually governed by the physical condition of the patient, preferably within six weeks for harelips and eighteen months for cleft palates. Routine preoperative care begins several days before operation, after the routine tests of urine, clotting time, and hemoglobin have been found satisfactory. Sodium bicarbonate every four hours and orange juice with sugar twice a day are given as precautions against possible acidosis. Argyrol 10 per cent, drops 2, is put in each nostril three

times a day for antiseptic purposes. No care is given on the ward to the lips and mouth except to see that they are properly cleansed.

In cases of harelip, after operation, rubber tubes of suitable size are placed in each nostril, and are secured to the cheek or nose by a thread of black silk or adhesive tape. They remain in position for three or four days. The suture line is painted with evaporated compound tincture of benzoin which is undisturbed for four or five days, and then sterile vaselin or boric ointment is applied to soften the benzoin before removal of the stitches.

Postoperative routine for harelip is:

1. Argyrol 10 per cent gtts. in each nostril, t.i.d.
2. Paint inside lip line with argyrol 10 per cent t.i.d.
3. Sterile water for first twelve hours.
4. Sterile liquid diet when nausea ceases. Mouth is rinsed with sterile water after each feeding.

Removal of stitches is begun on the fifth or sixth day and completed on the tenth day, after which time the patient is put on soft diet, and may be discharged.

Postoperative care for cleft palate cases is:-

1. Sodium bicarbonate, Glucose — āā 5 cc. to 50 cc. of water at body temperature per rectum every four hours.
   (The amount of solution is determined by the age of the patient.)
2. Sterile water for the first twelve hours.
3. Sterile liquid diet when nausea ceases. The mouth is rinsed with sterile water after each feeding, and the suture line painted with argyrol 20 per cent on an applicator well protected with cotton.
4. Argyrol 10 per cent gtts. in each nostril t.i.d.

After the stitches are removed, usually after twelve to fourteen days, the patient is put on very soft diet, and may be discharged.

A sterile blunt Asepto syringe or a sharp Asepto syringe protected by a rubber tip is used to give all nourishment.

It is important that these patients be kept quiet, and crying and talking prevented. Small doses of paregoric may be given if necessary. If children are very restless they may be placed on a Bradford frame. Cuffs made of cardboard covered with several thicknesses of gauze are placed over the elbow to hold the arms straight and prevent the fingers from being placed in the mouth. The patient must also be watched carefully for hemorrhage.

The transplantation of cartilage for the repair of saddle nose is also a frequent procedure. The costal cartilage, which is usually used, is removed under aseptic conditions. The wound is dressed as any other clean wound. The cartilage is transferred to the nose through an incision between the eyebrows or at the tip of the nose. The suture line is painted with evaporated compound tincture of benzoin, and a copper splint is moulded to the nose and secured by adhesive plaster. Nursing in these cases is much the same as that used for fractured ribs as the principal pain is in the area from which the cartilage is removed.

Plastic surgery is particularly interesting to the student nurses. The work on one patient sometimes extends over the entire period of training. The patient usually goes home for a few months between the different operations. Not only does the student become interested in the patient, but it is most gratifying to see function restored to a part, appearance improved, and the patient able to assume his place in society without consciousness of his defect.

The Speaker, the Audience, and the Program

MARY E. GLADWIN, R.N.

TO be the speaker guest at a nurses' meeting is a delightful and flattering experience. The guest is given the best room procurable; many attentions are showered upon her; there are drives to the places of interest; flowers brighten her room; many kindly and appreciative things are said about her efforts; and she too seldom hears the adverse criticisms. She goes away with a warm feeling of friendship for the nurses before whom she has appeared and an abiding interest in the nursing organizations of that particular locality. On the homeward journey, she finds time to ask herself whether she could not have been of more service to the group to which she talked, and then she begins to wonder how much circumstances over which she had no control combined to hinder her from doing her best. She remembers with pleasure the appeal of the earnest faces into which she looked.

The sensitive and conscientious speaker is, rather unfortunately, influenced by many external things. Her success depends largely upon the attitude of her audience and her own ability to change that attitude when necessary. Aside from any influence of her own, she knows that a small untoward circumstance may easily destroy the interest of the assembly and that intangible relationship which she establishes with such care. One sometimes reads a popular and much praised book with astonishment at its lack of appeal and its dullness but, reread under other circumstances, its charm is apparent. The speaker must overcome a similar apathy and preoccupation in the minds of many of her audience. One is sometimes told that the invited guest is temperamental and that her work is therefore uneven. The nurse who speaks without notes may be always so classified. On the other hand, it is that delicate appreciation of the feeling and attitude of her hearers which gives her the power to move and influence them.

The simplest things may decide the success of a meeting, and the outcome may be decided before a word has been spoken. The guest takes it for granted that the nurses want to hear her; otherwise she would not have been invited. She also believes that she has something to give which is worth while. Suppose that her talk is scheduled to take place immediately after the opening of the afternoon session. An anxious chairman has previously announced that the meeting will begin promptly on time, and she thinks it wise to appear on the platform early. Few speakers can afford to miss the opportunity of looking quietly into the faces of those they are about to address. If the inexperienced nurse, just learning to do without notes, forgets all about her speech for those few minutes and, instead, looks from one to another of the nurses before her, remembering who they are and the work they are doing, she is usually strengthened and comforted for the ordeal before her.

A little uneasiness and anxiety which is overcome as the talk goes on enhances the power of her appeal. When a speaker is free from nervousness and is entirely self-possessed, she is in immediate danger of losing her effectiveness. The effort to overcome her fright contributes to the mastery of her thought and words.

It often happens that those on the platform watch the seats in the back and middle of the house being quickly

filled, while those in front remain vacant. That constitutes a bad beginning for a successful program and, whichever horn of her dilemma the guest seizes, she wishes she had chosen the other. Making no comment, she may start on time. She warms to her subject and is well launched in her undertaking when the late comers, with obvious unwillingness and embarrassment, are one by one shown to the front seats. The audience is interested and surveys each one speculatively.

"Why, there is Miss A. I haven't seen her for an age."

"What a pretty new hat Miss B. has on!"

"Miss C is wearing the same old dress that she has worn to every convention within the memory of man."

"Miss D is reducing and it makes her look older than the hills."

The speaker sees all these comments, and many others, mirrored on the faces in front of her. She works a little harder, makes a desperate effort, but through it all she is painfully conscious that the continuity of her thought has been broken and its influence impaired. The attention of an audience is easily deflected. Unconsciously, we all welcome any interruption which saves us from making an effort, even that of listening.

Suppose the speaker takes the other alternative, whispering to the chairman, "Please ask them to move forward." Her suggestion is followed; the request is made. The audience, showing reluctance and annoyance in every step, moves slowly into the front seats. The annoyance and disgust of any one person is negligible, but the collective resentment at being disturbed can be felt and is another barrier between the speaker and her hearers.

To all speakers, and especially to the comparatively inexperienced one who is doing her best to discontinue writing what she has to say, empty front seats are a terrible handicap. Often, she is not able to look beyond them, and she cannot project her voice beyond the void of those awful rows of empty chairs. One who is used to speaking likes so get as near to her audience as possible. The physical proximity is symbolical of the mental and spiritual intimacy which she hopes to achieve. The woman on the platform and the women listening to her put out delicate little gossamer-like antennae of understanding and ideals which are easily bruised or broken.

One of the hardest tasks which falls to our lot as students and seekers after knowledge is to learn how to concentrate on the matter at hand. Every speaker knows how easily the thread of her discourse may be broken and how the point to which she is directing her argument may be missed. She may be doing well, with the eyes of all those in the assembly apparently riveted upon her. Suddenly, their attention is diverted by something going on behind her back. She becomes aware that two of the officers in the semicircle on the platform are on their feet and she hears chairs being moved. She wonders whether somebody has fainted and whether she ought to stop speaking. Presently, she is reassured by the sight of a beautiful and much belated basket of flowers which is being brought forward and twisted and turned so that the audience may have the best view of its beauty. Practically everybody in that room is thinking, not about what she is hearing, but about the beauty of the flowers and the identity of the sender. Instead of flowers, it may be that books and vases on the table beside her are being moved to make room for a forgotten tray and a pitcher of water. At the end of the address she

may catch the whisper, "She didn't speak as well as usual. What do you suppose was the matter with her?" She knows the reason, but it seems unkind to put it into words.

There must be two persons to a quarrel, to any sort of a contest, or any experience which is shared and, likewise, for a successful address there must be a prepared, earnest speaker, who need not be eloquent but who must be honest, and the composite personality of a sympathetic and appreciative audience. Within the first five minutes, the lecturer should be able to win approval and to overcome any obstacle in the minds of the listeners. After this harmony has been established, physical conditions may entirely spoil it; uncomfortable chairs, bad air, noise, and confusion are among the things to be noted and avoided the next time. To put on a play effectively, one admits that attention must be given to many small details which may spoil the success of the spectacle, and the same thing is true of any public performance.

Our programs are apt to be inordinately long. There may be several musical numbers, followed by a pleasant entertainment by a local humorist, the transaction of much business, and four or five short addresses, before the principal speaker is announced. The writer remembers an occasion when the music and the readings took up a full hour of an overcrowded program. Those who contributed volunteered their services; they spent much time and effort in preparation for the entertainment, which was pleasant and amusing. On the other hand, the speaker had come from a distance and she was being paid for her services. She had been asked to speak on an important educational subject, in the study and application of which she had had much experience. At the end of twenty-five minutes, the chairman whispered that the time was up, but that she might have three more minutes in which to conclude her remarks. She, at the suggestion of the program committee, was prepared to talk for an hour, but she could easily have arrived at a logical and understandable ending in forty-five minutes. As it was, the subject was left suspended in mid-air like the unfinished end of a bridge.

A nurse was invited to speak on nursing education at a state meeting of the Federation of Women's Clubs. She was told that, as the program was a long one, each speaker would be allowed twenty minutes. She was anxious to do well because the state contemplated legislative action in regard to the registration of nurses. The first three speakers were men and altogether they spoke for two hours and fifteen minutes. When the nurse stepped forward, the chairman whispered, "The other speakers used up so much time that we can give you only five minutes." Watch in hand, she talked exactly five minutes and as she turned to go the chairman took her by the arm, exclaiming, "I didn't know nursing was so interesting. You may have another five minutes." The nurse, appreciating the kindness behind the offer and the responsibility of the chairman, talked another five minutes, although realizing the danger of an anticlimax. It is doubtful, however, whether she did her cause any good by so doing.

An audience is the gainer when the speaker, well grounded in her subject and with plenty of material in reserve, decides upon the general tenor of her remarks, and is thereafter guided by the attention and interest expressed on the faces of those before her. Professor Palmer, of Harvard, tells us how horrified he was, in the early days of

his marriage, to discover that his talented wife, Alice Freeman Palmer, seemed to be making no special preparation for an important speaking engagement. He induced her, for the first and last time, to make a careful outline and to jot down important phases of the subject. At the end of the meeting, one of his friends said, "What was the matter with Mrs. Palmer today? Isn't she well?" It is evident that each one of us must work out the method best suited to her particular gifts, but we should be sure that it is not simply timidity which stands in the way of what we would like to do.

The Audience

IN planning a program, local or special conditions often need to be considered. Something like this may happen. The program is long and the chief speaker is not called upon until eleven-thirty, or until four-thirty in the afternoon. Everybody is tired. The air is none too good. Soon after she is started on the "Preparation of the Supervisor for Her Work," the supervisors and head nurses of the local hospitals, having had their afternoons on the previous day in order to do some convention work, begin to leave to go back on duty. In addition, certain other hospital people drop out in order to catch the only evening train to a near-by city, a train which leaves at ten minutes to five. The psychological effect of such departures is well known. The power of suggestion is so strong that others who ordinarily never would have thought of going, are moved to leave. The speaker works harder and harder, but her efforts are vain, for when she has finished the hall is half empty.

We do sometimes judge an address by its length, but an audience can seldom give close and profitable attention for more than forty-five minutes. The maximum time assigned to any speaker should be one hour and often it would be wiser to make it much shorter. The only exception made should be when a fascinating story is to be told or when stirring and moving events are to be narrated.

We have not yet realized the full value of free discussion or the part it plays in sending home an audience happy and satisfied. Everything which has to do with our educational methods or the ultimate details of our work should be presented from more than one viewpoint. Valuable plans and suggestions are often lost because the hearer does not know how to adapt them to her own work. A little discussion or the answers to a few questions would make the way clear or show her that the plan was not adaptable to her particular needs.

The best speech isn't the most finished and eloquent one; it is the one which arouses thought and creates opposition or dissent. The smooth, gentle flowing of a river over an even bed is productive of little power, but let that same volume of water surmount great obstacles, or fall over high precipices, and its power is intensified almost incalculably. The helpful things are those for which we struggle and which are not obtained too easily. The speaker may desire with all her heart to convert her audience, but if she is an honest, painstaking woman, she desires most of all to awaken them to a knowledge of their ability to think for themselves and to draw their own conclusions. More than that, she should welcome opposition if it is founded on honest belief. The ability to see both sides of a question is a rare gift, as is the open tolerant mind.

To repeat, if the address contains anything which is new, radical, or thought-provoking, it is a thousand

pities not to find time for sound discussion. If the audience needs a little time to think, it is helpful to suggest a form which objection or criticism might take and to appoint time for the discussion the next day. The member of the audience who is able and willing to say to a speaker, "I do not agree with you at all" and to give a reason, however halting, for her statement, is a public benefactor. There is no possibility of growth in continual agreement. There must be sharp and many differences of opinion in order to make progress.

Speakers from a distance do not always know local needs and they are in danger of forgetting that there are no panaceas for all our troubles. Few plans fit many situations without adjustments. The discussion is of great value to the speaker guest as well as to the members of the association.

Programs—Length, Coördination, Content

LET us go back to the consideration of the length of the program. The nurses who go to conventions are usually tired, but they are eager to obtain something which will help them in the continuation of their work. This eagerness is shown in the willingness with which they use vacation time for attendance at various meetings. It seems to me that no other body of women gives so freely of its time, money, and efforts for the sake of a profession. Intensive attention to a group of subjects cannot be kept up for many consecutive hours. The writer has in mind a program which included four addresses in the morning, a formal luncheon with two addresses, an afternoon filled full with speeches, and an evening banquet followed by a serious program which lasted for two hours. All the papers and lectures given throughout that long day were unusually good ones, prepared with the utmost care. It happened that one of the nurses was intensely interested in the subject of the first morning paper which contained material applicable to her own work. When her day ended at eleven o'clock, she said, "I feel as though I had been snatched from one emergency to another all day. The fire of my early morning enthusiasm has died out and I never can light it again. Then, you know, there is another long program tomorrow." Days spent in that fashion afford little opportunity for educational growth. They resemble more nearly a mental debauch.

Our program committees have rather a thankless task. They work hard to find suitable subjects and still harder to discover those who are willing to present them. They deserve our gratitude and should have much more help and appreciation than is usually given them. Days and programs such as those described in the last paragraph are the result of a bad old system which should be changed. They belong to that obsolete conception of education as the process of pouring knowledge into human beings as into jugs.

Year by year the topics are better correlated. Occasionally, we have a whole session given over to various phases of one topic so that we have, at the end, a feeling of having done a beautiful, finished piece of work, without many kangaroo jumps from one field of thought to another. One thing done well is better than a thousand skimmed over and superficially regarded. Some one phase of nursing education carried by a district through all the meetings of a year is a most satisfactory arrangement. A small standing committee, whose function it is to keep in touch with the new things in medicine and surgery

and to see that they are brought before the organization at an early date, will be found useful. It should be a very helpful adjunct to the program committee and its personnel should be fairly constant.

The nurses like, and find helpful, demonstrations of hospital methods, and nursing procedures. When there are only two or three fairly large centers of population, and many small communities, each with its hospital, the annual state meeting gives opportunity to extend valuable assistance to the nurses from the smaller places. If the secretary keeps a little book, with a list of all the demonstrations given year after year and the date and place where they are given, it helps in planning new demonstrations and repeating the old ones. The nurses from smaller places find useful an exhibit of trays set up for procedures with slips of their contents for distribution.

Each year it seems more difficult to obtain sufficient experience in the care of patients suffering from infectious diseases, so that the nurses are eager for demonstrations illustrating phases of this care. Even such a simple one as putting on and taking off the protecting gown is eagerly welcomed. The method of preparing a patient for discharge after an infectious disease and the care of his room with all its belongings is always a much appreciated demonstration. One should not be afraid of occasional repetitions in putting on demonstrations. It is inevitable and also invaluable.

To enlarge the scope of our efforts and in order to become better citizens, we need to be more fully informed about social conditions. If time could be found on the program of every state, and an occasional district, meeting for the discussion of some one of the sociological problems of the day, it would be very helpful educationally. There is, for example, that serious and disturbing question of the unemployment of millions of men. It isn't a simple question of a misunderstanding between employer and employee, and it isn't a new or an isolated phenomenon, or a question of today to be settled now for all time. It is apparently the tragic price we pay for progress. Its historical background is worth knowing and the story of the troubles incident to the introduction of machinery into the English mills, in the early part of the last century, furnishes a key to its understanding. The unemployment problem is one of the gravest of our day and it is pertinent to ask whether the unemployment among nurses has any relation to it.

We are apt to regard our own difficulties as things apart from the world around us and it is a belittling attitude. For example, we fight shy of any discussion of the differences between capital and labor, but we are not able to get away from their influence on our lives. We might very profitably hear a labor leader discuss this age-old problem and then invite a "captain of industry" to talk on the other side. The discussion would enlarge our understanding, no matter which one we disagreed with, or even if we discovered that we were not in accord with either.

Last year, John Dewey published a little book called "Impressions of Soviet Russia and the Revolutionary world, Mexico, China, Turkey." Dr. MacAndrew in reviewing it said, "In these observations you have psychology, sociology, education, and statesmanship presented in a manner which makes you realize the imminence of unusual events upon your own future." Because of that imminence

of the unusual, and because of what Dr. Dewey says of the Third International and its probable work in case of another war, a review of the book would be a good number for one of our programs.

It is helpful and pleasant to go back to some of the old books, such as the biographies of famous teachers. The "Life of Alice Freeman Palmer," by her distinguished husband, is charming and has in it much helpful material for all of us. The "Life of Maria Sanford" is illuminating. A study of the Civil War Sanitary Commission and the subsequent public efforts of some of the women on that commission affords a splendid background for our interest in relief or Red Cross work.

We might well find time for a frank inquiry into the divorce evil, not from a religious viewpoint, but in its relations to society and family life. We all know that we cannot build safely for the future without careful provision for the welfare of the children. We may well ask what effect has divorce on the children. A social worker and a thoughtful public health nurse who has been on her job eight or ten years ought to be able to help us. In this connection, somebody from a domestic relations court would be worth hearing.

Among all women there is needed more frequent and freer discussion of the marriage relation. What may be reasonably expected of marriage and what constitutes happiness in that or any other social condition? In all her life, the average woman probably does not spend ten consecutive minutes in thinking of the obligations marriage entails, or in viewing it either as a civil contract or a sacrament. The average popular novel or motion picture makes it merely a matter of physical attraction, wholly omitting the beautiful spiritual and mental experiences incidental to a true marriage. The mutual respect and helpfulness, the companionship, and fatherhood and motherhood, nobly realized as a means of continuing and strengthening the race of mankind, deserve thought and understanding on our part.

"The changes which are imminent" concern every one of us. Years ago, we used to hear Lavinia L. Dock speak courageously in behalf of woman suffrage when she had hardly one sympathizer in her audience. Everybody who heard her respected her honesty and her fearless expression of her convictions. For a long time we were afraid of being embroiled in partisan politics and we declared that a nursing meeting was no place for the discussion of a subject of that type. How short-sighted and bigoted we were. We understand now that any problem which has to do with the advancement and happiness of mankind is our problem. We know that any teaching which makes us more reasonable women and better citizens is a step forward in our development as nurses. As ever, we hope to avoid partisan politics, religious disputes and acrimony of any description, all of which furnishes a good reason for desiring to hear people of opposing beliefs explain to us the faith which actuates them. One of the most encouraging signs of the times is to behold the spectacle of a Jewish rabbi, a Catholic priest, and a Protestant clergyman coming together for the discussion of common interests, and finding it possible to work together amicably, tolerantly, and even affectionately, for the good of their fellow-men.

On every side of us is heard a cry for leadership. We ask for somebody to make our plans and decisions, to

point the way, and to control our deeds. This concept of leadership goes back to the old autocracies and is not suited to modern conditions. The true leader is she who stimulates us to greater effort and clearer thought, not the one who thinks for us and influences us to follow her like sheep. The great leader sees to it that we walk with her, and shows us how we may eventually pass her on the way. Our gifts are varied, but each one of us has something to contribute to the growth and leadership of our organization.

We conceive of leadership, adequate for the future, as a collective or composite thing. There will always be executives and administrators, but more and more they must become representatives of the thought, will, and purpose of the majority of the members. The valuable plans are the ones which lead us to make better ones. The address is most eloquent which awakens our ambitions, not for honors and political power, but for growth, for effective work, for that mental and spiritual leadership which enables us to contribute something valuable to the organization or society of which we are a part.

Psychiatric Education

THE two papers which follow were given at the First International Congress on Mental Hygiene in discussion of the paper on "Psychiatric Education" by Dr. Edward A. Strecker, Professor of Nervous and Mental Diseases, Jefferson Medical College, Philadelphia.

Dr. Strecker takes for granted the position of the nurse among the group of professional workers who care for the mentally ill. He does not limit this group of workers to the specialists in psychiatry but includes among them the general medical practitioner, the social worker and the nurse who does general nursing. He believes that there is a wide psychiatric segment in the general practice of medicine—as much as 75 per cent of the clientele of the general practitioner during the first years of his professional life. In spite of this very wide prevalence of mental disease Dr. Strecker finds serious deficiencies in the preparation of medical men, nurses and social workers. Of the psychiatric education of nurses, he says:

To a very considerable and serious extent, general nursing and social-work training are deficient in their presentation of the psychiatric point of view. This seems especially true of nursing. In the average training, the nurse receives a few formal lectures in psychiatry. An extremely common complaint and criticism of nurses even from excellent training schools is that, while skilled and superior in technic, they lack even an ordinary understanding of the psychological features of sickness. An already overloaded schedule would seem to preclude any radical revision. Some improvement would be noted if, as a part of each course—medicine, surgery, obstetrics, pediatrics, and so forth—there could be given, by the department of psychiatry of the hospital, an exposition of the psychological needs of the various groups of patients. Wherever possible, the nurse should have at least some experience in the out-patient psychiatric clinic of the hospital. The practice of affiliation with mental hospitals should be encouraged. Here the student graduate nurse will usually have access to an excellent course and splendid practical experience. Unfortunately, this experience is too often confined to frankly psychotic patients. A period of out-patient service, where border line situations and the neuroses are encountered, is extremely valuable.

For the nurse who wishes to become a psychiatric nurse, a longer period of preparation is imperative. This preparation should not differ much in kind from that given to the graduate student in psychiatry, although, naturally, it will differ in degree and will be much simplified and much less detailed. For the nurse who aspires to the more particularized and technical aspects of psychiatry, there should be a nursing apprenticeship under a psychiatric specialist, in the child-guidance clinic, in the industries, and in other fields. There has not been much utilization of nursing potentialities in these directions.

The two papers given here offer valuable suggestions in regard to this very real problem.

Part I[1]

CLARENCE B. FARRAR, M.D.

IN Dr. Strecker's paper he has kept so close to the current facts of a very rich experience that there is little with which one may quarrel, much with which one must cordially agree. He has raised one of the vital questions of instruction in which there is urgent need not only for more teaching but for more practical, useful and effective teaching.

I am today particularly interested in the question of nursing education, and so during the few moments allotted to me I should like to confine my remarks to that side of the question, and may I do so by suggesting three points of view: First, existing conditions; second, possible suggestions which might improve those conditions; and third, the results and consequences that we might look for.

If we start with the psychiatric clinic, which is an integral part of the general hospital, we come perhaps as near as possible to ideal methods of teaching. There is the rotation of services, medical and surgical nursing, and psychiatric nursing. Then psychiatric nursing is brought into its proper relationship with the other departments of medical teaching, neither overstressed nor understressed, but properly related and correlated. Unfortunately, there are still few general hospitals that have such a department, or that even have psychiatric wards. We are, therefore, for the present compelled to fall back upon the mental institution for a great part of the teaching which may be given in this branch. What is the result? We have two kinds of teaching, two kinds of nurses, if you please. We have the general nurse and the mental nurse, and often enough each kind hasn't very much use for the other. Why should that anomaly be? It is an echo of the traditional gap between psychiatry and the other branches of medicine. The standards of teaching in the two groups are necessarily quite different. The hospital standards altogether are often quite different, and yet it is through such affiliation only that by and large the general nurse can acquire some experience in psychiatric practice.

The psychiatric nurse differs in at least two important respects from, let us say, the surgical nurse. First, in the degree of authority which she must assume. All nurses must assume authority; they must control their patients, guide and restrain them as it may be necessary, but in a very particular way the psychiatric nurse must exercise authority to

[1] Discussion of a paper by Dr. Edward A. Strecker at the International Congress on Mental Hygiene, May, 1930.

control, so much so sometimes that the patient, fortunate or unfortunate as the case may be, is wholly subject to her will. The second point, and this was particularly stressed by the last speaker, is the predominant part which the psychiatric nurse must take in the actual treatment of the patient. We have learned in various papers of the importance of the psychotherapeutic element in psychiatry, an importance which is coming to be more and more recognized and evaluated. Can the doctor in his few moments, or his hour, or half an hour of contact with the patient, even daily, give all the psychotherapeutics that is necessary? Manifestly, he cannot; and unless the nurse has relatively as good a view, and certainly the same general view and the same general insight and discernment into the patient's mental activities as the doctor, such psychotherapeutic treatment as she may be expected to give cannot be given. She then, in contradistinction to the general nurse, has to assume rather a larger part in the actual treatment of cases, and it comes about not infrequently that the patient owes his recovery just to those ministrations which the nurse has been able to give rather than to the skill of the physician himself.

Now, coming to the second point of possible means of improving existing procedures, the question at once is raised rather more specifically of affiliation between the general hospital and the mental hospital, an affiliation in which the pupil nurse should live not less than three months actually in the special hospital and devote her entire time to that service, and during which her instruction would also be exclusively in that department. Would such an affiliation be feasible? In order to determine practically this question in one locality I made a survey of general hospitals of one hundred beds or more in the Province of Ontario which conduct training schools. There are thirty-seven that fall in this category, and the aggregate of the graduating classes of these thirty-seven general hospitals, last year, was 744. So that there would be need to provide for psychiatric affiliation for 744 nurses. Over against those figures I selected seven of the government hospitals which could contribute to this type of instruction. The aggregate number of pupil nurses in those seven provincial hospitals last year was 430, and that number could be considerably increased because there are still all too many attendants, who should be replaced by nurses. Conservatively we could say that almost immediately there should be 600 nurses in these seven hospitals. There are 744 nurses to be provided for. If you divide those by four, giving three months' training to each, then there are only 188 nurses to be given psychiatric instruction, so that we could provide for all the needs in the Province of Ontario three times over if we were to make a start immediately. This sort of affiliation seems to me to be something greatly to be desired.

As to the consequences, I will just read them by title: First, parity of service and standards between general and mental hospitals. Such a thing would be inevitable. The general hospital won't affiliate with the mental hospital unless the standards are the same. Second, uniform training for all nurses, just such as we aim to give all medical students. Third, psychiatric instruction and experience for all nurses in training. There should not be two more or less mutually exclusive types of nurse, but rather the general all-round nurse who has had psychiatric training. Fourth,

opportunity for development of advanced psychiatric nurses, and that is a subject about which I should like to speak if time permitted. Fifth, elimination of attendant class in mental hospitals and replacement by nurses. This should be accomplished gradually. I believe there should be no attendants except in the category of orderlies or occupational assistants. Sixth, the removal of the invidious distinctions between somatic and psychic disorders that still persist. Seventh, bringing psychiatric teaching and practice more intimately into the family of medical sciences in deed as well as word to the advantage of all concerned.

Part II[2]

MARY CHADWICK, S.R.N.

AS a representative of the British Nursing Service, I wish to express my deep gratitude to Dr. Strecker for what he has said about the important question of giving an adequate training to the nurse, to fit her for the responsible work she has to carry out.

It seems to be of the utmost importance to pay attention to this subject for the following reasons:

The nurse, whether working in a general or psychiatric hospital, engaged in private practice, as a visiting or school nurse, or any other branch of nursing service, is an integral part of the treatment of the patient.

The patient may see the psychiatric specialist once or twice maybe, the resident medical officer daily, or at stated intervals, but the nurse is there all the time. In private practice, especially in the case of patients suffering from neuroses or psycho-neuroses, she may be sent away to carry through a rest cure, and often she is responsible for that patient for the whole of the twenty-four hours, without intermission, which is necessarily a great strain upon her, both physically, mentally and nervously.

We may say, therefore, that she is prescribed as a special form of treatment, which is actually carried out by her presence, through her personality, and her attitude to the condition of the patient. This also makes a high demand upon the psychological make-up of the nurse for reasons which I should like to describe in as much detail as is compatible with the brevity the ten minutes allotted for this contribution demands.

The first reason I should like to bring forward for giving really adequate psychological training to the nurse, is for her own help, which I consider just as necessary as that which allows her to regard her patients with wider understanding, even if not more.

When she first enters her training school, often as a girl just from home, she meets a seamy side of life which may be new to her, and the symptoms of her patients are likely to disturb her own psychology, leading to shock, which often passes on to a greater or less degree of nervous disturbance. She requires help, therefore, to understand her own reactions to hospital life, to authorities, nursing and medical staff, and to her patients, and those of her patients to herself. Endless difficulties, which arise within the scope of interhospital relationships, will

[2] Discussion of a paper by Dr. Edward A. Strecker at the International Congress on Mental Hygiene, May, 1930.

doubtlessly occur to us from our own hospital experience.

There is also another reason why she needs psychological training from a different point of view, in order to understand her patients and herself, which is not often taken into account. Psycho-analysis has taught us that our attitude to life, to the people around us, and our choice of our profession, arises from our unconscious mind, our complexes, the fate of our infantile impulses and repression. Without some knowledge of these, we are blind to the causes of our difficulties and to many of those which seem to emanate from our patients.

When a nurse has learned to understand herself, she is going to find nursing the sick, and especially those who suffer from nervous or mental diseases, a new world to her.

How may she acquire this? From some knowledge of the information by which psychoanalysis has illumined the subject of neurotic conditions which occur by themselves or in alliance with other forms of disease; by suitable lectures, from a nurse trained in this particular way herself who therefore knows the problems which present particular difficulty to the rest of the profession, and by the reading of suitable books. Then she is ready to learn about the mental or psychological difficulties of her patients.

After that is accomplished, she will find that she gains the necessary understanding of her patients as follows:

1. Through understanding her own psychological mechanisms.

2. By means of particularly adapted lectures upon her own psychology and that of her patients.

3. By reading selected books on psychology and psychiatry to extend her knowledge.

4. Finally by means of her daily work and the constant study of herself and her patients.

Another most important matter to take into consideration is the choice of suitable persons for the work, and those who have the responsibility of this choice in their hands should be equipped with psychological knowledge, which will give them some clue, from talking to candidates for training, as to what are the motives for their wishing to adopt this profession, as well as to their fitness for the work.

Suggested Reading on the Nursing of Nervous and Mental Diseases

Stoddart, W. H. B., M.D.: *Mental Nursing.* Scientific Press, London.

Hart, Bernard, M.D.: *Psychology of Insanity.* University of London Press.

Sands, Irving G., M.D.: *Nervous and Mental Diseases for Nurses.* (Organic.) W. B. Saunders Company, Philadelphia, 1928.

Chadwick, Mary, S.R.N.: *Psychology for Nurses.* Wm. Heinemann.

Chadwick, Mary, S.R.N.: *Nursing Nervous Diseases.* (Functional.) George Allen and Unwin.

Mental Nursing

NO group of patients in any other hospital is so much in need of good nursing as those in the state hospitals. Mental nursing cannot be taught apart from the patient. Therefore there is needed on every ward a teacher, or teaching supervisor, who at all times can interpret the patients' needs and symptoms to the students and attendants and help them to make the application of their instruction. Nursing measures cannot always be prescribed in advance, for symptoms and reactions are as variable as the individual make-up and the presenting situation. The well informed nurse can anticipate and oftentimes prevent or cut short unfavorable symptoms while an uninformed or disinterested attendant may precipitate and aggravate symptoms.—"The Future of the Schools of Nursing in the State Hospitals," by Harriet Bailey, R.N., in the *Psychiatric Quarterly*, October, 1929.

Lesson Plan on "Fire Prevention and Fire Protection in the Hospital from the Standpoint of the Nurse"

MYRTLE HOLLO, R.N.

I. *Problem:*
How to prevent and meet the emergency of fire in the hospital and the nurses' home.

II. *Class:*
First-year students in the school of nursing.

III. *Time:*
During National Fire Prevention Week (October), if possible.

IV. *Aims:*
1. To give the students an appreciation of the frightful extent of human and material waste due to fire disasters, in order that they may feel their obligation in helping with the campaign against fires.
2. To familiarize students with the chief fire hazards in order that they may know better how to prevent the calamity.
3. To help nurses to understand and to appreciate the principles underlying the main features of the whole fire prevention program with especial emphasis on the hospital program.
4. To teach the program of fire prevention and protection in this particular institution.

V. *Brief Outline of the Lesson:*
A. "National Fire Prevention Week,"—meaning, purposes, special significance to nurses.
B. Fire and civilization.
C. Scientific principles underlying the causes and control of fire.
D. Development of organized systems of fire fighting.
E. Prevention of hospital fires.
  1. Building construction.
    a. Materials.
    b. Other corrective safety measures.
  2. Protective facilities and devices.
    a. Ample water supply.
    b. Standpipes and hose.
    c. Types of extinguishers.
    d. Fire alarm systems.
    e. Fire drills.
F. Rules and regulations in case of fire in this particular hospital.
G. How to move helpless patients from a burning room or building.
H. Common fire hazards.
  1. In the hospital.
  2. In the nurses' home.
I. Summary.
J. Assignment.

VI. *Illustrative Material:*
A. Statistical charts.
  1. Showing fire loss per capita in the United States and European nations.
  2. Showing annual fire loss in the United States due to various causes.
B. Posters and pamphlets from the national agencies for fire prevention.
C. Various types of fire extinguishers, used in this particular hospital.
D. Pictures showing old and new methods of fire fighting, hospital fires, firemen at work, methods of lifting and moving patients in a burning building, etc.
E. A reflectoscope.
F. Blackboard.
G. Equipment needed.
  1. Bed, wheel chair, stretcher, litter-blankets, Chase doll.
H. Procedure sheets.

VII. *References for the Teacher:*
A. *Fire Prevention and Protection as Applied to Hospitals*, National Board of Fire Underwriters, 85 John Street, New York, 1929.
B. *Fire Protection for Hospitals, Asylums and Similar Institutions*, H. W. Forester, National Fire Protection Association, 60 Batterymarch Street, Boston, Mass. Reprint from *N. F. P. A. Quarterly*, April, 1920.
C. *Safeguarding the Home against Fire*, prepared with the assistance of The United States Bureau of Education by The National Board of Fire Underwriters, 85 John Street, New York.
D. *Fire Exit Drill and Alarm Systems*, National Fire Protection Association, 60 Batterymarch Street, Boston, Mass.
E. Fire Prevention Bulletin, No. 18. *Fire Prevention in Public Institutions*, Insurance Department, Chamber of Commerce of the United States, Washington, D. C.

F. *Foundations of Chemistry*, Blanchard & Wade, Chapters IV, V and VI.

G. *Recommended Safeguards for the Installation and Operation of Anaesthetical Apparatus Employing Combustible Anaesthetics*. June, 1929. National Board of Fire Underwriters, 85 John Street, New York City.

H. *The Principles of Chemistry and Their Application*, Bartlett and Ink, pp. 49–53.

VIII. *Assignment Given out at Last Lesson:*

A. Locate the fire alarm boxes within a radius of five blocks of the hospital. What is the method of turning in the alarm from the box?

B. What are the characteristics of a fireproof building? To what extent do the hospital and nurses' home buildings measure up to these standards? References: "Fire Prevention and Protection as Applied to Hospitals," pp. 3–5.

C. What types of emergency apparatus for preventing fire disasters can you find in the hospital and home?

D. What are the main causes of fire calamities in this country? Which ones might be responsible for hospital fires? What are the greatest fire hazards in the nurses' home?

E. Study the sheet of Fire Regulations. Grasp their meaning and be ready to raise questions on them in the next lesson. (Sheets of mimeographed directions given to each student.)

F. Special assignments for student groups.

1. Lifting. (Review.)
   a. Bed to wheel chair.
   b. Bed to stretcher.
2. Reports. (Brief résumé.)
   a. "Report of the Cleveland Clinic Fire," May 15, 1929. National Board of Fire Underwriters, 85 John Street, New York City.
   b. "Safety Rules in Serious Fires," pp. 92–93. "Safeguarding the Home against Fire," National Board of Underwriters, 85 John Street, New York.
   c. National Agencies for the establishment of Fire Protection:
      (a) American Fire Prevention Bureau, Inc., 1 Madison Avenue, New York City.
      (b) National Fire Waste Council, Washington, D. C.
      (c) National Fire Prevention Association, 60 Batterymarch Street, Boston, Mass.
      (d) National Board of Fire Underwriters, 85 John Street, New York City.

Subject Matter	Method
IX	
A. *"National Fire Prevention Week":*	A.
1. October 5-11, authorized by President Hoover as National Fire Prevention Week.	1. Teacher discusses fire prevention with special application to the work of the nurse.
2. Purpose: To stimulate public interest in checking great fire calamities that this country is subject to.	
a. Fire loss in United States greater than in any other country.	
(1) Property loss in 1928—$473,000,000; more than cost of building the Panama Canal; equals one quarter the total sum necessary for maintaining all branches of our National Government, including Army and Navy; per capita loss by fire by far greater in United States than in any other country.	

(a) Fire Loss per Capita in 1924:

United States	$4.73
England	.72
France	.49
Germany	.28
Italy and Austria	.25
Switzerland	.15
Holland	.11

(a) Teacher shows statistical chart giving this information.

(2) Over 12,000 deaths from fire occur yearly in the United States.

(a) Life loss from fire is greater than that from any accidental cause in this country except automobile accidents.

(b) Over 17,000 individuals permanently injured by fire yearly. Many are hospital patients.

(b) How many patients in the hospital have you seen who are here because of fire disaster?

(3) Statistics show that in America there is an average of one hospital fire every day of the year.

3. Special Significance of Fire Prevention Week to Nurses.

The business of the nurse is saving lives. Preventive health programs seek to reach the individual before an invasion of the disease. Nurses might well think of fire as a disease, 90% of which could be avoided. Fire threatens public health and safety constantly!

Lecture.

B. *Fire and Civilization:*

1. Primitive man and fire.
   a. Fear of fire.
   b. Primitive methods of striking fire.
      (1) Rubbing two dry sticks.
      (2) Striking two stones.
      (3) Focussing rays of sun through glass.
         (a) Forest fires now due to action of rays of sun on glass. Duties of forest rangers.
   c. Fire worship.
   d. Greek belief, fire was one of the four elements composing the universe.

b. What methods were used by primitive man for obtaining fire?

d. How did the early Greeks regard fire?

C. *Scientific Principles Underlying Causes and Control of Fire:*

1. Fire is due to oxidation, a chemical change in which oxygen is combined with any substance.
   a. Priestley's discovery of oxygen 1774.
   b. Lavoisier, 1783, French chemist, proved by experiment that fire is due to oxidation. Without oxygen there can be no burning.

1. Define oxidation.

2. The air usually supplies the necessary oxygen.
   a. Fire-fighting methods based on this important principle. Always exclude oxygen to put out fire.

2. Teacher writes this statement on board for future reference.

(1) Methods of extinguishing fire by excluding oxygen:
Carbon dioxide.
Carbon tetrachloride.
Blanket.
Water which produces steam which cuts off oxygen.
Closing doors, etc., to cut off draughts.

(1) Name some common ways of excluding oxygen from burning substances.

Student demonstrates various ways of putting out fire by excluding oxygen, such as placing a tumbler over a flame, etc.

b. Exception: Gunpowder and nitrocellulose are exceptions because they contain their own oxygen.

3. Slow oxidation and rapid oxidation.

a. With all oxidation there is evolution of heat.

(1) Degree of heat depends on speed with which chemicals combine with oxygen.

(a) "Smothering" flames.
Preventing draughts.

(a) How is this principle made use of in checking fire?

(2) Certain substances more inflammable than others.

(a) Inflammable gas mixed with air in exactly right proportions for complete combination burns so fast as to explode.
Gasoline engine: Carburetor provides air mixture; electric spark sets it on fire.
Ethylene explosions in operating room.

(a) What is the principle underlying the use of ether to start a car?

b. Kindling temperature or ignition point is the degree of temperature at which any substance will "catch fire"; *e. g.* undergo rapid oxidation.

b. Distinguish between kindling temperature and combustion.

(1) Combustion is rapid oxidation:
Burning log.

(2) Slow oxidation is gradual combination with oxygen:
Rusting iron.
Rotting log.

c. Spontaneous combustion.

(1) Slow oxidation going on continuously in piles of oily rags, papers, coal, etc., in an enclosed space. Instead of losing heat, by radiation, that within the mass accumulates and raises temperature to kindling point, resulting in fire.

(2) Prevention of spontaneous combustion in the hospital. Do not allow oil mops, oily dusters, etc., to accumulate in enclosed places.

(2) How may nurses prevent spontaneous combustion in the hospital or nurses' home?

d. The temperature created by combustion of substances must be as high or higher than that of the ignition point. This is the second basic principle of fire fighting.

d. Teacher writes this principle on the board under the first.

(1) When one blows out a burning match, one's breath carries away the heat, reducing the temperature of the match stick below the ignition point.

(2) Directing a cold stream of water on a fire is an application of the same principle.

(2) How does the fireman apply this principle?

D. *The Development of Organized Systems of Fire Fighting:*

1. Fire is a community problem as well as a matter of personal concern.
   a. Volunteer and professional fire fighters.
2. Early New York City history records purchase of 200 leather buckets for fighting fire in 1659.
3. Benjamin Franklin an official of the first fire insurance company in America.
4. First electric fire alarm invented 1847 by Moses G. Farmer, a telegraph operator.
   a. Technic for turning in an alarm from the street:
      Open red alarm box.
      Pull down lever, let fly back.
      Wait at the box for the firemen to appear
5. Use of horse-driven teams.
6. Use of motor engines and trained men.
   a. Firemen are given course of formal instruction, examinations, and a period of probation before being accepted on the regular staff.
7. Educational programs are being conducted to bring about the following:
   a. Complete inspection by the fire department.
   b. More general use of fire-resisting roof coverings, protected windows and door openings, and automatic sprinklers.
   c. Adequate means of convicting incendiaries.
   d. Suitable ordinances governing the storage and use of explosives and combustibles.
   e. Intelligent use of fire alarms and first-aid extinguishing devices.

Report by student:
"National Agencies for Fire Protection."
Writes name and address of four on board.

a. Locate the fire alarm boxes within a radius of five blocks of this hospital. How would you turn in an alarm from the street? Teacher refers to the picture showing parts of alarm box.

7. What are the essentials of a good community fire-prevention program?

E. *Prevention of Hospital Fires:*

1. Building construction.
   a. Materials.
      (1) Laboratories of the National Fire Underwriters scientifically test all materials.
      (2) Roof and floor construction should be of non-combustible material which will resist fire of 1700 degrees F. for four hours—concrete or concrete and gypsum tile.

b. Basic principles of fire-proofing:
   (1) Isolation.
   (2) Division.
   (3) Separation.
   (4) Confining fire to its place of origin.
   (5) Protection of things beyond the immediate fire zone.

c. Corrective safety measures:
   (1) Standard enclosed stairways and elevator shafts to cut off each floor.
   (2) Adequate fire stopping at all stud partitions and furring at all floor and ceiling lines.
   (3) Automatic sprinkler systems generally throughout the building if more than two stories high.
   (4) Fire walls with standard fire doors to cut off large horizontal floor areas.
   (5) Ventilators of incombustible construction and protected so that sparks cannot fall on the building.

c. What safety devices did you find were used in this hospital?
   Teacher lists these on board as they are suggested by students and in each case the basic principle is named and explained.

2. Protective agents.
   a. Ample water supply provided in the vicinity of the building.
   b. Standpipes and hose.
   c. Fire extinguishers of various types: soda and acid; loaded steam or foam.

c. Teacher shows fire extinguishers used in this institution, discussing chemical principles involved. The method of using each is stated but demonstration is planned for a definite time soon when the engineer will show the students how to operate each.

   d. Adequate ventilation of all places where combustible anesthetizing agents are stored to prevent approaching the lower limit of the explosive range of anesthetic gas-air mixture.
   e. Electric motors used in rooms where combustible anesthetizing agents are used or stored should be of explosion-proof type.
   f. Use all possible measures for guarding against ignition of combustible anesthetizing agents through the static spark. Floors, trucks for moving cylinders, anesthetizing gas-piping system, etc., should be properly grounded.
   g. Precautions should be taken against having fire of any sort, from open gas flames, smoking, cautery, etc.
   h. Vapor-proof lamp globes in anesthetizing and operating rooms.
   i. Fire-resistive vaults for x-ray films and volatile fluids.

j. Organization of fire brigade among hospital attaches.

k. Fire alarm systems.
Every nurse in any hospital should learn exactly where the alarms are located and what the specific hospital regulations are in regard to fire as soon as it is possible to do so.

l. Fire drills.

(1) Fire prevention and protection are important features of Scout programs. One great difference between the procedure in a hospital and an ordinary institution is that in the hospital, nurses report to their stations in the event of fire, whereas in other buildings all inmates leave at once.

k. Report: "Safety Rules in Serious Fires."

F. *Rules and Regulations in Case of Fire in This Hospital:*

F. Teacher refers to typed sheets of printed regulations, copies of which are posted in this hospital in definite places. Teacher and student discuss each statement. (See assignment.)

FIRE REGULATIONS[1]

IN CASE OF FIRE

(1) Go immediately to red fire alarm box. (Fire alarm boxes in corridors on each floor.) Open door, pull hook to stop and release hook.

(2) *Notify* telephone switchboard operator of location of fire.

(3) Secure fire extinguisher, if the building is equipped with one, and operate same on fire. To do this, *turn extinguisher bottom up and play on fire.*

If there are no extinguishers, go to hose box, carry nozzle of hose to place of fire, turn on water at hose box connection *if the case is urgent*, and play water on the blaze.

Fire hose in main hospital is located on each stairway—in other buildings on each floor.

NURSES AND ORDERLIES

Nurses on duty shall report to their respective wards and patients and there remain till called.

They shall close all doors and windows, lower shades, turn on lights, and make ready all stretchers.

Should removal of patients become necessary, care shall be taken that all are accounted for.

Nurses, especially supervisors and charge Nurses, will inspire their patients by their own quiet behavior during a fire.

INTERNES

At the first alarm bell, residents and junior internes shall at once go to that part of the hospital where their service patients are located.

House internes shall report to floors having private and semi-private patients, not less than one to each floor.

They shall reassure patients by their poise and quiet demeanor and stand ready to assist in carrying out all regulations having to do with an alarm of fire.

ELEVATOR OPERATORS

At an alarm of fire *operators* will bring their cars to basement and there await orders of Chief Engineer. If the fire is *not* in the building where elevator is located, the car may

[1] Fire Regulations of the Jewish Hospital, Brooklyn, N. Y.

be used as needed. If the operator is in doubt as to location of fire, car shall be held in basement subject to orders of Chief Engineer.

EMPLOYEES

Each *employee* shall immediately go to that part of the hospital where he or she works.

All doors shall be closed, shades lowered, and lights on.

Do not run. Stand by to do what is necessary to extinguish the fire and calm any excitement.

Admitting clerks shall guard entrance doors, admitting none but hospital authorities, police and fire departments and employees.

In laboratories, gas shall be turned off at all burners and all electrical machinery stopped.

The chief engineer is in charge after an alarm of fire. He shall start the fire pumps and go at once to the location of the fire. He shall cause a fire drill to be held at least once a month and shall report to the superintendent in writing any derelictions of duty, absence of personnel from stations, or other conditions present not in accord with these regulations.

RECALL

Signal for recall at end of fire will be 3–1–2.

Fire positions will be held by all personnel until recall has been sounded.

G. *How to Remove Helpless Patients from a Burning Room or Building:*

1. Removing patients from bed to fire escape or stairway.
   a. Bed to wheel chair.
   b. Bed to stretcher.
   c. Blanket drag.

G. If these procedures have been taught in a lesson on lifting and moving helpless patients, previously, special groups of students may have been asked to review them and demonstrate at this point. In any event practice periods are arranged for the same in order that the teacher may be certain of the students' technic.

H. *Common Fire Hazards:*

1. In the hospital:
   a. Careless use and storage of X-ray films.
      Use of the nitrocellulose type rather than the acetate type, which is far less inflammable.
   b. Anesthetical apparatus employing combustible anesthetics without safeguards. Static electricity, open flames, cautery, etc.
   c. Defective installation of heating and ventilating apparatus, including piping.
   d. Poor housekeeping, rubbish, ashes, etc.
      Spontaneous combustion from oil mops, etc.
   e. Smoking and improper use of matches.
   f. Lack of protection against outside exposure.
   g. Improper installation and use of gas appliances.
   h. Defective electrical installations and careless use of electrical equipment. Dangerous shades on electric light bulbs, etc. Electric cautery, etc.
   i. Carelessness in the storage of drugs and chemicals of an inflammable nature.

Name all the hospital fire hazards you can think of.

Teacher lists them on the board, discussing prevention in each case.

Report: Cleveland Clinic Fire.

2. In the nurses' home:
   a. Careless use of electric iron, hot plate or gas stove in kitchenette.
   b. Smoking and improper use of matches.
   c. Dry cleaning.
   d. Toilet articles, etc., made of pyroxalin plastic.
   e. Open fireplaces left unscreened.
   f. Careless use of candles.
   g. Christmas-tree lighting, short circuits, etc.

How can nurses help prevent fire disaster in the nurses' home?

I. *Hazards Contributing toward the Spread of Fire:*
1. Unprotected floor openings.
2. Lack of fire stopping.
3. Large undivided areas.
4. Excessive heights.
5. Combustible roof coverings.
6. Skylights and ventilators which permit entrance of sparks.
7. Cracked and bulged walls or walls of inferior construction.
8. Ceilings, walls and partitions sheaved with flimsy materials.
9. Poor foundation or lack of foundation.

Name some of the hazards contributing to the spread of fire.

J. *Hazards Contributing to Panic in Event of Fire:*
1. Insufficient number of exit doors.
2. Lack of horizontal exits.
3. Exits adjacent to open shafts and otherwise improperly arranged.
4. Exit doors not equipped with panic bars or opening inward.
5. Locked and obstructed exit doors.
6. Fire escapes which are not erected according to accepted standards.
7. Steep, narrow and dark stairways with many turns and obstructed landings.
8. Narrow and obstructed halls.
9. Absence of guards on stairways.
10. Loose, worn out and improperly spaced stairway treads.
11. Improperly designated exit doors.
12. Improperly illuminated passageways.

What are some of the hazards contributing to panic in event of fire?

Teacher spends about five minutes showing pictures of hospital fires, firemen in action, statistical reports, etc.

A lantern will add to the effectiveness of this part of the lesson.

K. *Summary:*
1. Fire in the United States is a very serious problem.
2. There is on the average a fire disaster every minute of the day, somewhere in this country.
3. Hospital fires occur, on the average, once per day in the year.
4. Every nurse should know:
   a. What to do when a hospital fire breaks out.
   b. How to turn in an alarm in the hospital and on the street.
   c. The best way to remove a patient from a burning building.

d. How to escape from a smoke-filled room.
e. How to administer first aid to anyone burned or suffocating from smoke.
f. How to fight fire *before* it starts, by learning what causes fire and then removing these causes, so far as possible.

L. *Assignment:*
1. Attend demonstration given by engineer on the use of fire extinguishers and fire hose in the hospital and home. (Definite time stated.)
2. Attend next fire drill given in the hospital. (Teacher arranges special emergency drill if necessary.) Definite time stated.
3. Practice in classroom on various methods of lifting and removing patients until technic meets with approval of instructor.
4. Be on the alert to notice all the uses of fire in nursing treatments studied in the future, with the idea of protecting patients and preventing fire disasters.
5. New type examination on content of this lesson with emphasis on the points contained in the procedure sheets studied.

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Hourly Nursing[1]

From the Viewpoint of the Registry

LYDA W. ANDERSON, R.N.

IT may be assumed that we are all agreed that hourly nursing is a partial solution to the ever recurring problem of our past Biennials that of meeting the nursing needs of our large middle-class population. It is also the most promising gesture toward answering the questions involved in the economics of nursing; that is, the best distribution of nursing care, and we are agreed that it must be offered as an organized service. Apparently the questions we now want answered are: How and with what organization shall the hourly service be established? and Who shall give this service so as to best reach the largest number of patients?

Heretofore in our plans and policies offering organized hourly nursing, we have gone along the line of least resistance. We have accommodated ourselves to the means at hand, by using the local visiting nurse association for the direction and distribution of the service. We have naturally accepted conclusions offered us by speakers at previous Biennials, and built on these conclusions; they were conclusions reached by those who were authorities on nursing affairs. I am thinking especially of a paper read at the last Biennial on "The Larger Problem of Community Nursing," and of the very interesting and exhaustive report we heard at the International Conference of Nurses on the "Economics of Nursing." Quoting from the first mentioned article, two important points necessary to consider in establishing this service:

> Hourly nursing, for example, can only be developed to full advantage when conducted by a well organized public health nursing group which *can furnish expert supervision and can take up the slack of the nurse's time* by using her in other fields of visiting nursing as occasion offers.

The conclusions, briefly stated, from the second-named paper are:

> 1. That the greater part of the total nursing care in the home will be done by visiting and hourly nurses.
> 2. That there are not enough nurses in the field at present to give this service to the patients who, we feel, need it.
> 3. That the service when well established will maintain itself.
> 4. That the service must be offered as an organized service.
> 5. That since visiting nursing is already organized as a community service, and since the difference between hourly and visiting nursing should surely not be one of quality, and probably not one of content, but merely of administrative detail, these two could be very well combined.

When we heard this summary of facts based on reliable statistics, and listened to the conclusions reached, we felt that we could with confidence enter upon the development of this particular service, *hourly nursing*.

There are evidently questions in the minds of many of us concerning the conclusion that hourly nursing service is best discharged and rendered most useful when absorbed by a visiting nurse association. The subject given me to offer to you for discussion suggests that organizations other than the visiting nurse associations might well concern themselves in the direction and distribution of hourly nursing.

The speaker preceding me has proved that at least one visiting nurse association can assure us that the

[1] Read at the Biennial Convention of the the three national nursing organizations, Milwaukee, Wis., June, 1930.

experiment with hourly nursing has been a success. Reading the reports of organizations which have carried hourly or appointment service for some time and hearing answers to questions on hourly nursing put to the physicians and his patients, we can hardly rest satisfied that we have gone very far on our way in meeting the community's total needs as far as this form of nursing is concerned.

Are we actually reaching a proportionately larger number of patients needing this service than we did before we began to talk earnestly about organized hourly nursing? Likely not, and probably the only reason that would be given would be that we need more publicity, *that promotion of the service only awaits public education.* Then we ask, are there any peculiar difficulties in enlightening the public when hourly nursing is absorbed by the visiting nurse association? Is there any real hindrance in making the public understand that there is this distinct service offered them? In other words, is it especially difficult to reach the public mind, because it is difficult to get our prospective consumer to recognize hourly nursing service, as such, when administered by a visiting nurse association? Are they still looking upon the visiting nurse association's reason for existence—a service to the poor, and therefore not availing themselves of it? Is the visiting nurse association making its service conspicuously health education, or rather is it because the health-education emphasis of this organization precludes too much attention to the hourly nursing feature? Is a registry experiment apt to be more successful in meeting the public needs, and will these hindrances not present themselves, naturally, when the service is directed by the registry?

I have no experience other than that with the "free lance" method, upon which to base any arguments for or against the question of our official registries giving this service. No registry has yet experimented independently with organized hourly nursing for a long enough time to be ready to advise. My statements, therefore, are mainly opinions of those who have given serious thought to what should constitute a program of adequate nursing service for the community as a whole, giving special thought to hourly nursing. The plan of organization where a registry establishes hourly nursing must be quite similar to that of a visiting nurse association. The nurses must be selected for this particular work; they must be distributed from a central headquarters; they must report to the headquarters; they must have a place for consultation and advice, and the whole project would have to be promoted through a plan similar to that of a visiting nurse association. We are led to believe that the only reason the registries have not been active in establishing and promoting hourly nursing up to the present time, is that there is not enough in their treasuries to institute this service.

Conforming to a plan of organization has no difficulties. There are nurses enough to carry the work, and the registry system could easily include this service with other nursing services. We are satisfied it can be made self-supporting, but there may be a period before it becomes self-supporting when it would have to be subsidized. This seems to be the reason for procrastination, for we are still a bit timid whenever an exceptional effort is required of us, or when we must "detour" from a rather fixed way of doing things. Our traditions, as a profession, glorious as they are, do shackle us at times. They delay

us in doing some experimental piece of work, spontaneously, when we wish to step out of the beaten path. I repeat, there are no reasons why a registry should not be able to furnish organized hourly nursing. It only requires a bit of determined effort and the development of some plan whereby the service can be financially supported until it has become established on a self-supporting basis—conditions which need not be taken into consideration when hourly nursing is simply absorbed by an already existing public health nursing organization. The question that naturally comes to our minds with this statement is, Why invite seemingly unnecessary difficulties when we have a perfected plan of organization at hand? The question of promoting hourly nursing, as well as all other types of nursing services, should be considered with reference to the country as a whole. We must keep in mind every type and size of community, and we are bound to prepare ourselves to conduct this service independent of any specialized organization, limited in its territory, so as to be able to meet the *total* nursing needs of *all* communities.

We are not speculating as to the advantages or disadvantages of the registry carrying this organized hourly service, nor are we thinking of the advantages of the service being carried by a visiting nurse association, compared to the service the registry might organize, neither are we speculating as to any peculiar situations involved with either organization. It is a question of how to bring about a greater distribution of this particular service, and we are therefore asked to consider the question of hourly nursing from the viewpoint of the registry, an already established system for nurse distribution. We say that hourly nursing is "visiting nursing by appointment." It may also be defined as "intermittent" or "fractional" private duty nursing. We may contend that the private duty nurse who has equipped herself specially for bedside nursing and to satisfy a very demanding private patient, may be more successful as an hourly nurse to the patient who pays hourly nursing rates and expects his individual wishes to be catered to, than a nurse who is part of a standardized, less flexible system.

We have it recorded that as soon as the Grading Committee had only peeped into the existing nursing conditions, the Director said:

> The most effective way of remedying the situation (*i.e.*, supply and demand of nursing service) might be to provide the nursing services needed through the establishment of central registries of a type not now known. These registries would be under the direction of a highly paid, professionally-minded nurse. They would be clearing houses for the use of nurses, doctors, public health workers, hospitals and patients; but they would be more than that. They would take all the nursing material available and classify it according to types of cases which each group of graduates could properly handle, always mindful of the community's needs. There would be a definite attempt, that is, to provide the doctor with the sort of co-worker he wants, to provide the patient with the nursing care he needs, and to place the nurse in the sort of position where she can do good work and be happy.

At this time the registries began to be conscious of the fact that while they had stated their aims and purposes to be "to provide nursing services for the community," they were really only registering private duty nurses. They were fulfilling a function as limited as that of creating a center which was merely a convenience whereby a particular nurse could be easily reached when the hospital or the physician or the patient in the home needed her, and where the nurse could register for cases. Becoming

more and more aware of the public's rightful demands upon it, and recognizing that its real reason for existence was to offer an adequate program of nursing service for its own community, these nursing bureaus we call official registries are now beginning to be conscious of sins of omission. Might it be suggested that the name be changed? The psychology of using a label which suggests a very limited activity is rather bad. The term registry no longer applies to the office or bureau which has as its main purpose "to meet the community's needs for nursing care." We expect of it "a central bureau for the distribution of nursing services," and should give it a name which defines this purpose. It may be well for our larger district nurses' associations to check up on what is probably their main activity, *i. e.*, an official registry, to learn if this activity keeps faith with the community's needs, and functions according to its expressed purpose.

At this national meeting we are accepting minimum standards for official registries. We hope that it may be possible for our 69 registries to meet such standards. These standards are the very least we have a right to demand of an organization which has such great potentialities for community service as our official registries. During the process of standardization, I am assuming that we shall develop, with the registries, all the needed nursing services. It will be an attempt to standardize and make more potential an already existing organization, but the "consummation devoutly to be wished" is a central bureau from which *all* nursing services are dispensed. From such an office would be distributed nurses for continuous bedside care, hourly nurses, visiting nurses, supplementary nurses, male nurses. It would give the service of a vocational bureau, it would be a placement bureau for the executive nurse, etc., a center with unlimited possibilities. It would be the center to which the sick person would apply regardless of type of disease, his individual preferences, or his economic status. He would know that at such an office or bureau or agency, his particular needs would be investigated and he would be supplied with nursing care according to his needs. He would understand that these services had been prepared and were supervised by a professional organization, for as a profession, we must assume the responsibility for initiating, preparing and supervising the services necessary for the care of the community's sick. The public and the medical profession will assume a definite responsibility in establishing and promoting these services. In such an agency it would be possible not only to centralize all nursing services, but it definitely would be organized to improve all the services. It would be in control of, and would keep up to the highest professional standards all the nursing services it offered. It would be an agency that would do the necessary research work. This is probably what we should discuss first, before considering the promoting of any special nursing service; first learning what are our unmet community nursing needs. Might not *this* be the keynote to our final structure? Our National Director once said to me in discussing community services and the registry's responsibility: "Is it because we have not made a definite effort to find out what are our unmet community nursing needs?" At the same time she asked another question: "Is it because we have not made a drive for reëducation of the public in its home use of nursing services, and because we have not a consistent and

thoroughgoing education program tapping on the eyes and ears of our potential consumers?"

May I say again that the nursing profession has the responsibility of initiating and preparing nursing services, but the public has an equal responsibility with the nursing profession in establishing and promoting the use of these services. To meet this responsibility, the public must be informed. The apparent difficulty in reaching the public mind is that it requires reëducation. "It is easier to form than to reform," and it is also much easier to educate where there are no preconceived ideas than it is to reëducate. In the public mind, the nurse today means a 12-hour-a-day nurse for $7, if the patient is in need of bedside care. We nurses have, for the last several years, been aggressive in maintaining that the sick must be in the care of a graduate, registered nurse continuously, and we have allowed no exception. We have done this in order to establish nursing as a profession, and in order to preserve standards. Any form of supplementary service, any form of substitution, was taboo. After these many years of talking along a certain line, and cramming definite policies down the public's throat, it is going to be difficult, naturally, to make it at once comprehend something different. This reëducation is our big task. When the public, our potential patients, and our physicians, recognize that there are various types of nursing services to be had, and when the patient's needs for nursing care will be as carefully analyzed and diagnosed as his needs for medical treatment, a better adjustment will immediately follow.

If we could proceed at once with a central organization plan of this kind, we would not present any particular service from the viewpoint of any particular organization. The service would be considered altogether from the viewpoint of the patient, and if we are looking at it from the viewpoint of the patient, we will start now on the groundwork, centralize our resources, find out what are the needs, and work consistently to create this central agency which will direct all the services for all the sick. This presupposes a joint council on community nursing in control, with full representation of all the intra and extra-mural groups who would be responsible for the *preparation* of nursing services, for the *direction* of nursing services, and who would *use* the nursing services. They would be hospital representatives, schools of nursing representatives, members of the medical profession, and full representation from the extra-professional groups.

Might not then the deadlock in ou progress at present—the task of reeducating the public—become inconsequential? When it is understood that all nursing services for the sick, with no exception, are distributed from one center; and that the organization directing the service will, first of all, seek to know the sick one's needs, and then supply his individual needs; and that it is in the control of the patient himself, the doctor and the nurse, it would seem that the publicity would be in "satisfactory service rendered," and public enlightenment would be a natural growth with the service.

In these precious moments given me in which to discuss with you a subject that I find has led me into many entanglements, I have tried to say:

1. That the public will look to the nursing profession to prepare, to initiate and to supervise the necessary nursing for the community.
2. That the nursing profession will, at the same time, demand that the public take its

responsibility in establishing and promoting these services.

3. That we seem just now to be particularly interested in a special type of nursing service, namely, hourly nursing, because it is going to give the greatest good (nursing service) to the greatest number (of patients, economically).

4. That we should urge upon other nursing organizations, other than an established public health nursing organization, to create and promote the service, and that each organization promoting the service concern itself in the best means of reëducating the public

5. That we might profitably analyze our registry situation and learn if these agencies are keeping faith with their community's needs, and fulfilling what they themselves define as their aims and purposes.

6. That we do not overlook communities where there are neither visiting nurse associations nor registries, nor any other perfected functional nursing organization, and that we prepare a plan to promote nursing services in all communities.

This last thought makes one wonder if we might not approach the whole situation from another angle. May I remind you of a suggestion given us by our friend and advisor, Dr. C.-E. A. Winslow, at our last Biennial, when he said: "I can foresee in the future that in every well-ordered community there will be a joint council on community nursing."

We need to know what our present unmet needs of the community are, our Director tells us. We need to know what our nursing resources are. We need to carry on a program of public education. We need to have a more thoroughgoing agency for the distribution of nursing services. We need to have a better supervision of all the nursing services. Even more than the need for public education, which we talk so much about, we need better conditions in the group representing the largest part of our membership—the private duty nurse. "The reasonable hours, adequate income, constructive leadership and opportunity for growth," which our Grading Committee asks for this group, is not coming to pass very rapidly.

It might simplify matters, it might remove some of our present perplexities, some of the deadlocks that we are struggling against, if we think first of a comprehensive organization plan. We would begin by forming a joint council on community nursing. In this Council would be created a bureau of research (That would be "the definite effort to find out what are our unmet community nursing needs"), a bureau of public education ("to make a drive for reëducation of the public in its home use of nursing services, and to prepare a consistent and thoroughgoing education to tap on the eyes and ears of our potential consumers"), a bureau of private duty nursing organization,—any bureau, that is, to cover any particular line of nursing service needing special attention. I hope there is no one shuddering for fear that our professional standards might not be sufficiently protected. If the nursing profession makes the first move in this direction and brings about the establishment of such a joint council on community nursing, with proper representation, there will be no danger that the profession will not have full enough representation to safeguard its standards. It seems to me it might rather intrigue us to think along this line.

We teach our students today to think of the patient as a whole. Following the same principle, we might better think of our collective patients as a whole, and not single out any one type of service. We need to concern ourselves with the preparation of an adequate program of nursing services under the control of a joint council on community nursing.

A First Graduating Class

At the American Women's Hospitals School in Greece

EMILIE WILLMS, R.N.

FIRST CLASS GRADUATED FROM THE AMERICAN WOMEN'S HOSPITAL TRAINING SCHOOL FOR NURSES, KOKKINIA, PIRAEUS, GREECE

Dr. Angenette Parry, Obstetrician, seated in center; on her right, Dr. Ruth Parmelee, Medical Director; Miss Willms standing back of the two doctors.

THE American Women's Hospitals Training School for Nurses was opened in Salonica, Greece, in January, 1923, and was reorganized in Kokkinia, Piraeus, in November, 1927. It held its first commencement exercises in May, 1929, graduating eight nurses at that time.

Dr. Parmelee started the training school in Salonica in 1923, at a time when the organization could not see its way clear to send over a fully qualified nurse to do the work. Having herself started out toward nursing as a career, until Fate directed her into the medical profession, her keen interest in, and her knowledge of, the need for well trained nurses has never waned, and so she held on tenaciously against all odds until the school was reorganized in Kokkinia in 1927.

There are many such medical missionaries in the Near and Far East, who guide and direct young women into nursing channels, step by step in a slow and tedious fashion, until they see their way clear to send them to a recognized school. These women are seldom heard of, but we as a nursing profession have every reason to be grateful to them.

The three nurses who are to go to the United States commenced their course in her school at Salonica. Just what graduating, with the additional course ahead, and looking forward to the final goal of taking an integral part in raising nursing standards in Greece, means to these young women can only be appreciated when we try to realize that they are refugees who came from Asia Minor after the Smyrna catastrophe in 1922. Because of this disaster, the need for nurses was so great in Greece that they served for long periods among the refugees, in hospitals of this organization, thus interrupting their nursing course. The courage with which they finally reached their goal has brought forth many comments of admiration.

The training school follows the

OPENING MOSCHATO CLINIC IN A REFUGEE SETTLEMENT OUTSIDE OF ATHENS, GREECE, NOVEMBER, 1929

curriculum of the National League of Nursing Education and its preliminary educational requirement is a minimum of two years in the high school or "gymnasium," with the full course in either as the goal. Instruction to the students is given in Greek and in English. The students who do not know English or Greek must add a language course to their subjects.

Along with the theoretical and practical work in the surgical and medical departments, the students have pediatrics, dentistry, eye, pathology, and public health. An outstanding midwifery course is given. Some of the students deliver over one hundred babies before the completion of their course. In the public health department are included visiting nursing, prenatal, preschool, and infant welfare clinics, ophthalmological and general clinics, and record-keeping.

The teaching staff in January, 1930, consisted of six qualified physicians and three graduate nurses.

The hospital has eighty-one standing beds and, under normal conditions, carries a daily average of fifty-eight patients. In case of the not infrequent epidemics, the hospital is prepared to care for over one hundred patients, by means of a little crowding.

Four of the recent graduate nurses are doing responsible charge work in the various departments. There are enrolled at present seventeen nurses, of whom three should be graduated within six months and three others in about a year. The last of these students will finish about the end of 1932.

Nursing and training nurses in mud barracks is a marvellous experience. It taxes ingenuity to the utmost, but is truly rewarding. Behold a general clinic full of human misery of every

kind in the morning; again filled with little children suffering from trachoma and all sorts of eye diseases during the afternoon. A bulletin reminds the nurses that it is recreation night—such hustling to get the cleaning women at work; such hunting for the door-boy after the place has been aired to make a little fire in our ancient stove to dry out the dampness; then a few touches here and there, and presto! see before you Recreation Hall.

An alumnae association, the first in Greece, has been formed, and all of the 1929 class have been accepted as full members of the Greek National Nurses' Association. Since the National Association is a member of the International Council of Nurses, this gives them international standing as graduate nurses.

Reading a cablegram from New York stating that Nurses Vassiloghlon, Ioannidon and Yeonadon were accepted as postgraduate students at Bellevue Hospital, March first. Drs. Parmelee and Parry enjoying the thrill.

An Anatomical Correlation Study[1]

ELLA BEST, R.N.

THE "Anatomical Correlation Study," by Wilna Slapak, which appeared in the August *Journal*, represents a correlation between the human anatomy as taught in the course of anatomy and physiology, and conditions with which the student comes in contact in her care of the patients on the wards of the Cook County Hospital.

The subject as presented in the classroom and laboratory is intended to give the student a knowledge of normal structure and function from which she gains through her work with patients, an appreciation for certain deviations from the normal, the pathological. This method of approach helps the student to see the importance of certain nursing procedures in the care of her patients as well as aids in increasing her interest in the physiological processes involved in the course of the disease. Such a plan of presenting the subject introduces the student to life situations and reduces to a minimum the memorizing of abstract detail, a principle recognized as being desirable in general education. For example, the simple procedure of turning or moving the patient in changing the drawsheet may be more intelligently done, with less discomfort to the patient, if the student has more than a superficial knowledge of the body muscles. Many other examples might be given but

[1] Some of our readers have asked for an elucidation of the study which appeared in the Student Page of the August *Journal*.—Ed.

the following will serve as representative illustrations: the management of weights in the care of fractures involves an understanding of the physiology of muscle and bone in injury; the spread of a so-called "cellulitis" is made clear through an appreciation of the wide distribution of deep and superficial fascia; the care of a thyroidectomy is more effective if the student has an understanding of the infra-hyoid muscles, the blood and nerve supply of the thyroid gland; the care of a patient with a radical breast amputation is more intelligible when the student understands the lymph drainage of the mammary gland and the reason for the extensiveness of the incision into the axilla; certain symptoms may be anticipated in the care of a patient with fractured cervical vertebrae if the student has worked out the formation, distribution and function of the nerves of the brachial plexus.

The outline used is a simplified form of taking note of correlated conditions and is intended to stress the fact that anatomy and physiology are not isolated sciences but representative of a body of knowledge with most practical applications. The nursing care is not included in this inventory summary of correlated conditions but is presented by the instructors in the various nursing departments whose entire time may be devoted to the subjects which they are expected to teach; namely, the care of the patient in the various types of medical, surgical, pediatric or orthopedic nursing.

The spirit of interest and enthusiasm demonstrated by the student in the study of anatomy and physiology and its relation to the actual care of her patient as well as favorable reports from supervisors, instructors and Assistants to the Dean are evidence that such a course does meet the students' needs in a manner that is most vital and real. Students with this background give more intelligent bedside nursing care to their patients which is the aim of all nursing education.

During ten years' experience in teaching the subject of anatomy and physiology, the author has tried various methods of presenting the course with laboratory dissection of many types of vertebrates. At no time have the students acquired and applied information more satisfactorily than at present through the dissection of cadavers, which has been made possible through the efforts of Laura R. Logan, Dean of the School of Nursing, Cook County Hospital, Chicago.

Prevention of Bed Sores

MARTHA M. RUSSELL, R.N.

REMARKABLE success has attended the efforts in one institution to cure and prevent pressure sores on incontinent paralytics who lie in the same position for years at a time, and this description of the method is sent in the hope that it may prove useful:

The patient is lifted to a stretcher and then into the bathtub at least two or three times a week.

Newspaper pads having a layer of cotton and covered with gauze are kept under the patients constantly, and changed frequently.

Dermalgen powder, mixed with equal parts oxide of zinc powder, is used freely.

The immediate and rapid improvement in the condition of patients who are admitted with bad bed sores is very gratifying.

The Student's Share

SINCE student nurses spend most of their time not in the classroom, but on the ward, it is necessary for the Grading Committee to ask what that practical experience means in terms of education. How far is it true, for example, that the students now being graduated have all had properly balanced experience in the medical, surgical, operating room, obstetric, and pediatric services, and in the diet kitchen? Does the patient have assurance, merely because the nurse has been graduated from an accredited school of nursing, that she has had thorough training in each of these essential services?

According to records submitted by the schools for the experience of their 1928 graduates, there were 65 students in Massachusetts who spent 365 days, or more, on the surgical service, 32 such students in New York, 51 in Pennsylvania, 154 in Ohio, 92 in Minnesota, and so on. Records run as high as 750 days for a single student. Where students spend one or two full years on surgical duty, how much time have they left for anything else? Time spent in the operating room does not vary so widely; but even there casual inspection shows schools reporting individual students who spent 350, 355, 367, and 400 days; while in the same schools there may be other students whose experience in these services lasted a month or less.

Because variations in length of student experience are an excellent index to the amount of care which the school gives its educational thinking, a series of diagrams has been prepared, two of which are reproduced here. They deal with the differences in student experience in surgical training and in the operating room. Each diagram consists of a series of blocks, strung side by side on a central thread, so closely that they form a solid black surface. Each block represents a group of schools; and the total number of blocks from left to right represents in the first diagram the total 932 schools whose reports on length of surgical service are used in this study; and in the second diagram, the 1,128 schools giving information covering operating room experience. In each case, half way across the diagram from left to right represents half the schools; one-third of the way across represents one-third of the schools; and so on.

The height of each block, from

SCHOOLS REPORTING EACH SPECIFIED DIFFERENCE IN LENGTH OF EXPERIENCE BETWEEN THE FIRST AND THIRD QUARTILE STUDENTS IN EACH OF SIX SERVICES

Months Difference	Medical	Surgical	Operating Room	Obstetric	Pediatric	Diet Kitchen
Under 1	355	257	748	535	683	931
One	377	358	266	361	213	122
Two	147	189	81	131	63	19
Three	43	74	21	49	20	2
Four	11	31	5	17	2	
Five	4	10	5	4	1	
Six or more	8	13	2	3	2	
Total	945	932	1,128	1,100	984	1,074
Per cent 1 month or more	62	72	34	51	31	13

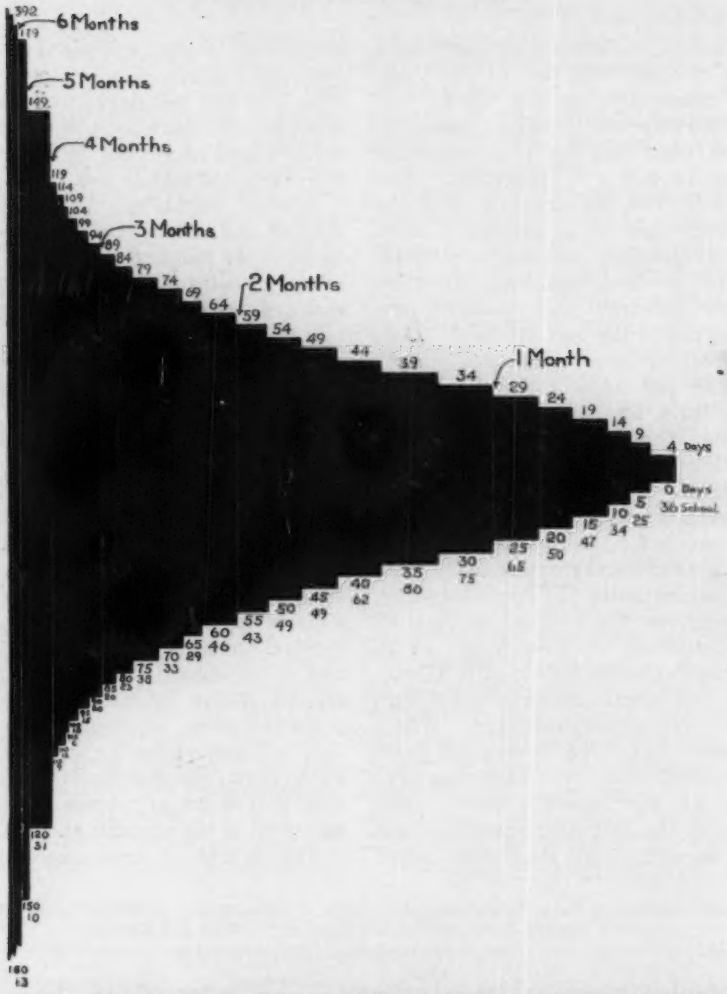

DIAGRAM 1.—Schools reporting difference of from 0–4 days, 5–9 days, 10–14 days, etc., in time spent on surgical service by students in the 1928 graduating class. Distance across the page shows numbers of schools. Distance up and down shows differences between first and third quartile students in the same school.

bottom to top, represents the days' difference in length of service between students in the same graduating class in each school. At the extreme right of Diagram 1, for example, is a block of 36 schools in all of which the differences in length of surgical service were from 0 to 4 days. Behind that is another block of 25 schools, where the differences were from 5 to 9 days. At the extreme left is a block of 13 schools in which the differences between students were from 180 to 392 days.

In order to avoid extreme cases, and

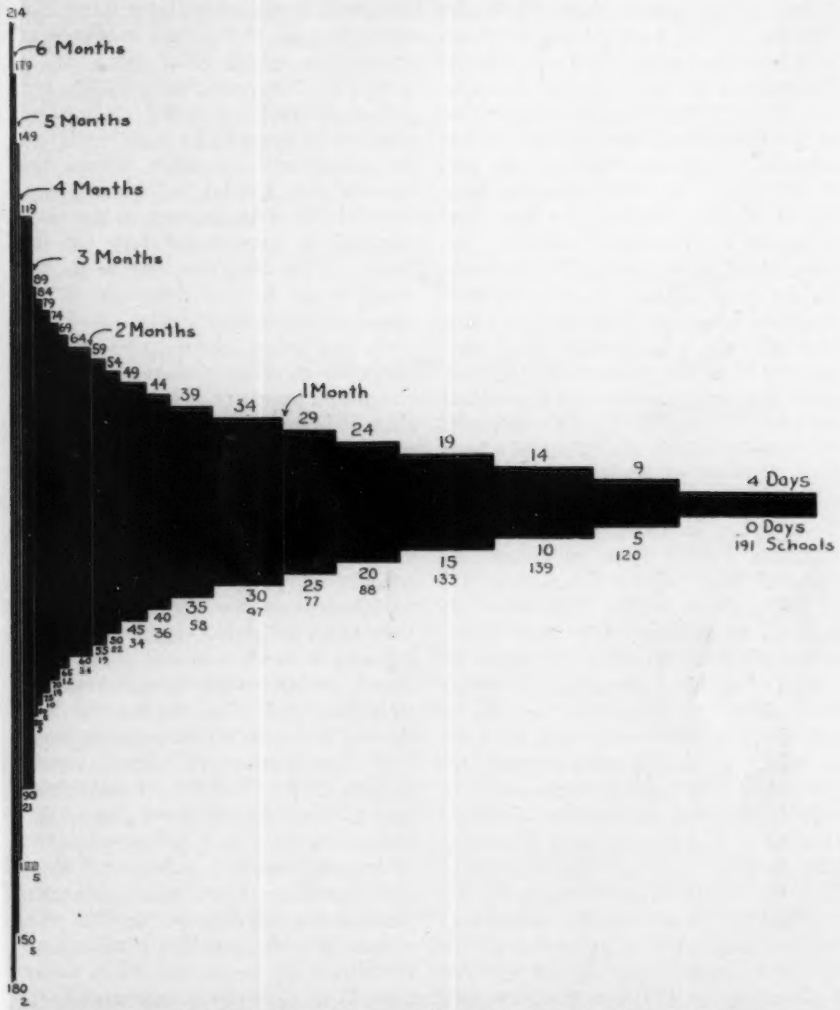

DIAGRAM 2.—Schools reporting differences of from 0–4 days, 5–9 days, 10–14 days, etc., in time spent in the operating room by students in the 1928 graduating class. Distance across the page shows numbers of schools. Distance up and down shows differences between the first and third quartile students in the same school.

secure as fair a measure as possible for each school, student records in a given service were arranged in order from the shortest to longest, and the difference found between the student one-quarter of the way up, and the student three-quarters of the way up. Throughout this article, where range of experience is discussed, it is based on this quartile comparison.

It will be noted that each diagram is cut into portions by a series of white

lines. These breaks show where the months come. A comparison between the two diagrams indicates marked differences in educational practice. In the diagram showing operating room experience, two-thirds of the schools are to the right of the one month line. In other words, two-thirds of the schools have less than a month's difference between the amounts of service secured by students in the same class. On the surgical diagram, however, the one month line cuts off only a little more than one-quarter of all the schools, and it is not until the two months' line is reached that we find two-thirds of the schools. The blocks which are extremely long from bottom to top, showing great differences between students, occupy little space in Diagram 2, but in Diagram 1 they form an important part of the whole silhouette. Of 932 schools reporting differences in surgical experience, 128 had differences of three months or more in length of surgical experience between students in the same class; and in 13 schools these differences were over six months. In the operating room, on the other hand, there were only 33 schools showing differences of three months or over among their students, and in only two schools were the differences six months or more.

These are conservative measures, since extreme cases have been omitted and comparisons have been made not between students at the bottom and top of the class, but between students one-quarter and three-quarters of the way up. Were the range for the entire class made the basis of this study, each diagram would consist of blocks considerably taller than those shown here. Even with this conservative handling, however, there is clear enough evidence to show that in many schools students in the same class are apparently being assigned to the essential services not according to the actual amounts of experience which they need for a properly balanced background, but rather according to some other criterion which seems to have little relation to education. In other words, the studies give ground for the suspicion that length of assignment to the basic services is determined not by the needs of the students, but in all too many cases by the demands of the hospital for nursing service.

In any large school there must of necessity be some variations between the actual numbers of days on service, since it is not always possible to shift groups of students from one department to another after exactly equal periods. There should, however, be some agreement as to how many days of variation are legitimate. The 36 schools showing less than 5 days' variation in surgical service have come very close to giving equal periods of experience to all students. Yet what about the other schools represented in that diagram? Can all the 257 who showed less than one month variation feel equally content? Since nearly three-quarters of all the schools taking part in the study reported greater discrepancies than they between lengths of student surgical experience, these 257, therefore, know that their own practice is much more stable than that of most schools; yet does it follow that variations of, say, from 20 to 24 or from 25 to 29 days are legitimate? If one month's leeway is acceptable, how about two months? If two months is too long, where should the line be drawn?

The table on page 1285 shows that similar problems arise for each of the major services.

Full details of these comparisons will be made available, in confidential form, to the schools which joined in

the First Grading Study. We hope that as a result of these studies, and of others which the League, the university schools, and other groups are already undertaking, there may be made available to nursing educators everywhere a series of recommended standards, showing how much variation between students may be considered allowable, and how much should be considered a danger sign indicating that the assignments of students are being determined not by educational needs, but by the pressing demands of a busy and understaffed hospital.

Miss Goodrich Goes One Step Farther

THIS last study of the Grading Committee is certainly timely. There is probably no aspect of nursing education that so imperatively demands study and analysis as that of the required content of clinical experience to be included in the undergraduate or basic course in nursing. It is a complex problem, not easy of solution.

That this basic undergraduate course should include clinical experience in the four major branches, Surgical and Medical Nursing, Obstetrics and Pediatrics, is generally conceded. The great advances in the field of preventive medicine and the growing understanding of the interrelationship between the psychic and the physical, has increased rather than diminished the importance of a comprehensive and intensive clinical experience in all of these branches.

The great variations that this last study of the Grading Committee reveals in the clinical experience of the students, evidences only too clearly the subordination in the great majority if not all of the schools of the student's experience to the immediate needs of the hospital during the brief period of her professional preparation, rather than basing the content of the experience on the professional service to be rendered to the community.

It is our belief that the clinical experience, not less than the theoretical courses, should be determined on an hourly basis and that any deviation from the number of hours accepted as essential should be slight. A few weeks, even a few days, overtime in one service inevitably cuts into the other not less required experiences. Three years is barely sufficient for the clinical experience which would be of great value to the practitioner of nursing, but the three years as now interpreted in the majority of hospitals is an exploitation of both student and patient, and we feel that again the Grading Committee has put a finger upon one of the greatest weaknesses in nursing education as at present interpreted.—ANNIE W. GOODRICH, R.N.

Our Contributors

Dr. William S. Middleton of the University of Wisconsin Medical School and **Marion Zilley**, instructor in the School of Nursing, collaborated in preparing the article, "Blood Pressure Determination." Dr. Middleton prepared the manuscript and Miss Zilley secured the illustrations.

We are indebted to **Elsie Bond** of the New York State Charities Aid Association for assistance in securing data for the article on nursing in almshouses.

Jessie P. Wilson, R.N., B.A., a private duty nurse, is a graduate of Wellesley College and of the New York Hospital School of Nursing. She has had postgraduate courses at Sloane Maternity Hospital and at Columbia University. Miss Wilson says, "There is no monotony in private duty, for every patient presents a new problem and new interests, scientific or social."

The admirable article on "Empyema in Children" by **Dr. Patrick J. Mahoney**, Surgical Resident at the Children's Hospital, Boston, Mass., was illustrated by **Frances K. Clyde, R.N.**, the Surgical Supervisor.

Dr. W. W. Charters (Ohio State University), having applied his highly trained critical powers to the nurses he has observed in action, arrives at some interesting conclusions.

Marion Crissman, Union Memorial Hospital School of Nursing, Baltimore, Md., 1924, has had experience as a supervisor in her own school and at Stanford University School of Nursing. She was instructor in practical nursing at her Alma Mater. Illustrations for her article were provided by Dr. John Staige Davis of Baltimore. She has recently become Superintendent of Nurses at Jefferson Hospital, Roanoke, Va.

Mary E. Gladwin, R.N., Ph.B., is devoting her time to institutes and other professional programs and to writing.

The symposium on Psychiatric Education was part of the program of the Mental Hygiene Congress. **Dr. Edward A. Strecker** is Professor of Nervous and Mental Diseases, Jefferson Medical College, Philadelphia. **Dr. C. B. Farrar** is Professor of Psychiatry at the University of Toronto and **Mary Chadwick, S.R.N.**, is an eminent British nurse and the author of an interesting *Psychology for Nurses*.

Myrtle Hollo, R.N., Ph.B., graduate of the University of Minnesota School of Nursing, is at present a student at Teachers College, Columbia University, where this lesson plan was prepared and used.

Lyda W. Anderson, R.N., is Executive Secretary of the Detroit District of the Michigan State Nurses' Association.

Emilie Willms, graduate of the Homeopathic Hospital of Essex County (Newark, N. J.) and Superintendent of the American Women's Hospital, Kokkinia, Piraeus, Greece, had a varied experience, including private duty, social service and tuberculosis work, before going to the foreign field.

Ella Best, R.N., M.S., as has previously been noted in the *Journal*, has resigned from the faculty of the Cook County Hospital School of Nursing to become Field Secretary of the American Nurses' Association.

Martha M. Russell, R.N., is now Superintendent of Nurses at the Municipal Hospitals, Trenton, N. J., where good care of chronic patients is a matter of pride and satisfaction.

Mrs. Janet F. Korngold, R.N., M.A. (Presbyterian Hospital School of Nursing, Chicago), is Director of the School of Nursing, Touro Infirmary, New Orleans.

Harry C. Biddle is Instructor in Chemistry, Western Reserve University, Cleveland, Ohio.

The Reverend Alphonse M. Schwitalla, S.J., is Dean of the School of Medicine of the University of St. Louis and President of the Catholic Hospital Association.

Some Specialists

Lydia Breaux, R.N.

JANET FENIMORE KORNGOLD, R.N.

SOME people say that ten years is the working lifetime of a private duty nurse. After that, the scrap-pile! Others say that private duty is a rut, a place to bury aspiration and ambition. The career of Mrs. Lydia Breaux is a most happy contradiction to these dreary misconceptions of the possibilities of private duty. It was in 1900 that Mrs. Breaux graduated from the New Orleans Sanitarium Training School for Nurses. From that time until last year, when she accepted a teaching supervisorship in the private pavilion of Touro Infirmary, Mrs. Breaux's work as a private duty nurse was interrupted only by the still more strenuous activities of 1917–1919 when she saw service with both the American and British Expeditionary Forces.

MRS. LYDIA BREAUX, R.N.

Presumably, all institutions expect —or hope for—in a staff nurse these principal characteristics: a sense of economy and a respect for equipment; an extensive knowledge of nursing; a personality in which the ability to meet people and to make discriminating adjustments of both large and small difficulties is very prominent; and the faculty for instructing the student personnel and inspiring its confidence and coöperation.

Mrs. Breaux's early environment was undoubtedly a large factor in the development of those qualities which have brought her success. In these days when the American home has so largely ceased to function as an institution of educational value to its daughters, the virtues of the family life of three or four decades ago stand out in bold relief. Mrs. Breaux was born on a Louisiana plantation and shared in the multiplicity of its activities. She became an excellent *ménagère*, a master of the details of household economy; *jeter l'argent par la fenêtre* was never a virtue in her French eyes. In her many years in the homes of New Orleans, no family ever had occasion to lament her

mismanagement of the household supplies and equipment. Touro profits by this skill, at a time when so few women make of *faire le ménage* a fine art.

Mrs. Breaux is more than a supervisor; she is a hostess. She radiates welcome and hospitality. Those in whose families she has nursed find it comforting and satisfying to be on her floor in the hospital. After her long period of private nursing—she never found home cases objectionable—she forms a link of friendship, as it were, between the institution and the community. She knows the community and the community knows her.

In the opinion of the Touro School of Nursing, one weakness of contemporary nursing education is the great separation which so often exists, both in time and location, between instruction and its application. Lecturers describe symptoms in auditoriums, not by the bedside; instructors demonstrate in classrooms, not in sickrooms; instructors rule the schoolroom, supervisors rule the hospital, and the ideas of instructors and supervisors are not always identical. This produces confusion in the mind of the student nurse.

To overcome this divorcement of theory and practice, Touro upholds the policy "every instructor a supervisor; every supervisor an instructor." And the most valuable service a supervising instructor can render the student is guidance in the observation and interpretation of symptoms. Is the treatment producing results? Is the patient comfortable or uncomfortable? What evidence is there to support your opinion? What do you see to make you believe that danger is passed? that danger is imminent? The simple, Socratic method of instruction, the dialogue method, between the seasoned nurse and the young student, is the best way, says Touro, to produce thoughtfulness and comprehension in students. Mrs. Breaux, because of long, wide-awake contact with individual patients, under circumstances making possible the most concentrated observation of details, has acquired a knowledge of nursing, and in this kind of intimate and personal instruction she gives the younger generation the benefit of her experience.

They tell us private duty is "narrowing," but Mrs. Breaux has always had many and diverse interests. She has had the social spirit, thinking always of the needs of the professional group. In the midst of long workdays, she found time in 1912 to play a prominent part in the organization of the Louisiana Nurses' Association. For many years she was its president. For a number of years she also served as secretary to the Louisiana Committee of the American Red Cross Nursing Service. And last but not least she has found time to fulfill the rôle of a loyal mother, and an adoring—and adorable—grandmother!

The inimitable George Moore writes in his memoirs:

> I did not go to either Oxford or Cambridge. . . . I can lay no claim to scholarship of any kind; for save life itself I could never learn anything correctly . . . contact with the world is in me the generating force; without it what invention I have is thin and sterile. . . .

Of course, Moore is a creative genius; but is not nursing also a fine art? And might it not be that too great an emphasis on academic methods in nursing education, threatens that education with "thinness and sterility"? Let us not get too far away from the "generating force" of which he speaks. Lydia Breaux is one who has learned nursing and life itself, correctly. *Agréez, Madame, nos salutations et nos compliments les plus empressés!*

Editorials

Thirty Fruitful Years

A Birthday Gift

MANY factors enter into the success of nursing projects. On the solid foundation of Mary E. P. Davis' "capacity for sustained drudgery" and for courageous action the ever growing superstructure of the *American Journal of Nursing* rests.

When the magazine was twenty-five years old, nurses in many cities celebrated with gorgeous birthday cakes the growth in circulation and in usefulness which they had helped to bring about. Now it is thirty years old and, instead of asking others to celebrate, the *Journal* is sending a gift to all the accredited schools of nursing. The gift, the *History of the Journal*, has been put in pamphlet form for the use of those who teach the history of nursing, for the story of the *Journal* makes a shining page in that history. We think that the principals of the schools will watch eagerly for this pamphlet and see that it is filed with other reference materials in the school library, but they will not file it without reading if they permit themselves even a glimpse within the covers.

The story of the *Journal* is not merely the story of the magazine. It is a stimulating story of courageous striving toward a much desired objective which will put new heart into those who have grown a little weary in well-doing. Some of the profession's greatest names are indissolubly woven into the pattern—Miss Palmer, Mrs. Robb, Miss Nutting, Miss Dock, Miss Riddle—these are names to conjure with; and the list of stockholders (See frontispiece) is a veritable roll call of the eminent of that day.

The magazine, now the property of the American Nurses' Association, is the professional gift of these great women to the nurses of the world. Said Miss Davis, in those arduous days of preliminary committee work:

> I have always contended that if the foundation was laid securely along proper lines there was not much danger but what the superstructure would be a success. We are certainly laying the foundation no matter who builds it . . . let them find it as nearly faultless as possible, not cramped or narrowed down to meet one person's ideas but with every avenue for expansion and improvement open.

After thirty years, those who follow have reason to bless the fine sincerity, the rugged honesty, the tenacity of purpose and the acumen with which the foundation was laid. Growing steadily in splendid usefulness, but weighted always with serious problems, the profession finds much use for the magazine. In these days of search for a solution to the unemployment problem, for sound types of organization for our educational programs, for inclusive programs of distribution, the *Journal* is needed as never before. A perusal of the story of the early struggles of the magazine which is now so taken for granted, will bring renewed zeal to those of today who, like Miss Davis, possess "a capacity for sustained drudgery" as well as clear vision and great courage.

The story of the *Journal* will be delivered to the principals of the schools just after this *Journal* has been

received. A few extra copies will be available for state boards of nurse examiners and for state associations upon request.

The Student's Share—and the Patient's

"DOES the patient have any assurance, merely because a nurse has been graduated from an accredited school of nursing, that she has had thorough training in each of the essential services?" asks Dr. Burgess in her current article "The Student's Share." The answer, based on the most careful compilation of the schools' own statements obviously is *No, relatively few patients have such assurance!* Sixty-one schools report differences under ten days in length of surgical services, and only thirty-six, differences of less than five days, while at the other end of the scale there are schools with variations of 180 days and upward to the point where some students apparently spent their entire training period on surgical services.

"Dr. Burgess has put her finger on one of the weakest spots in our whole system of nursing education," writes Adda Eldredge, after perusal of the manuscript. "When emergencies arise, superintendents of nurses far too often meet the emergency by transfer of students from the stations from which they can most easily be spared without reference to the student's program."

This is not the first time this shockingly uneducational procedure has been brought to light! No portion of the earlier study of nursing education in the so-called Rockefeller Report was more vividly presented than the conflict between the educational program of the school and the administration of the hospital's nursing service.

How did the thirty-six schools which report variations of from 0 to 4 days achieve their aim? If thirty-six were successful in balancing services, can others do likewise? Obviously, what thirty-six can do, others can do, if they will plan the programs of nursing experience with the same care they give the theoretical program.

Supplementing student service with graduate service, a cardinal principle in nursing education and one long advocated by Miss Goodrich in her teaching and one carried out not only at Yale and the University of Wisconsin, but in an increasing number of other schools, is sound practice. "Even without such suplementary service, there is reason to believe that many schools can make more careful assignments than they habitually do," says Miss Eldredge.

It cannot be done without a careful plan and faithful adherence to the plan. Methods vary, but the principle must everywhere be the same. When assignments are being made, whether on the first of the month, at other stated times, or in emergency, records must be easily available which show the total time already spent in each service. With such a record before her, a conscientious principal will not willingly add days to an already completed service.

Dr. Burgess' data imply a very serious weakness in educational thinking on the part of many directors of schools of nursing. It may be assumed that all of them are deeply concerned with the care of the patients under their supervision. True educational thinking implies acceptance of responsibility, not only for the quality of the care of patients in the hospital, but also for the care of those patients whom their graduates will nurse through the years subsequent to commencement day.

Until programs of practical experience for student nurses are worked out and adhered to with the same care given to the theoretical program, a negative answer must be given to Dr. Burgess' question, "Does the patient have any assurance, merely because the nurse has been graduated from an accredited school of nursing, that she has had a thorough training in each of the essential services?"

Nurses in Shelby County

PUBLICATION number six of the Committee on the Cost of Medical Care "A Survey of the Medical Facilities of Shelby County, Indiana, 1929," contains some exceedingly interesting data. Shelby County was chosen for study because it seemed to be as nearly typical of a midwestern rural county as any county which might be found.

Nursing services are described as rendered in three different ways: by private duty nurses of two kinds, registered and practical; by hospital nurses; and by the public health nurse. "There are available for private duty nursing," says the report, "two registered and about twenty-five practical nurses." The one hospital in the county is staffed by graduate nurses. Registered nurses are easily secured for special duty in the hospital and for private duty from an Indianapolis registry.

Many factors appear to enter into the startling disproportion between registered and practical nurses. Among these are (1) the cost of registered nurses, (2) the disinclination of nurses to leave the "bright lights" of the city, (3) the tendency to register not only against rural calls but also against certain types of cases.

The total expenditure of private duty nursing in the County in 1928 is estimated at $14,500. Of this sum $3,200 went for hospital specials; $3,300 for registered nurses in homes; and $8,000 for practical nurses.

Only about one-half of the maternity patients in the county have nursing assistance and it is obvious from the account given of the preparation, or lack of it, of the practical nurses that those who do have their service cannot be receiving high type care, although it may satisfy the present desires of the patients. Conversely, the income of each of the two private duty nurses is lower than that of some of the practical nurses.

Considering that Shelby County is considered to be a typical rural midwestern county, the study opens a vista of nursing opportunity.

Stimulated by the reports of the Grading Committee and guided by the American Nurses' Association, which is devoting much of its attention to the whole question of the distribution of nursing service, nurses everywhere are beginning to think in terms of community organization for all types of nursing service. Speed the day when skilled nurses and patients needing their skill may be brought together for longer or shorter periods at rates which the patient can afford to pay and which, when pooled through efficient organization and administration, will provide incomes commensurate with the preparation and skill of the nurses.

Hospital Fire Drills

FREQUENTLY the question is asked, "Just what should fire drills in hospitals consist of?" No detailed answer that will apply in general can be given. The organization of fire drills is a subject for separate consideration in each hospital; there must be taken into consideration the number and location of exits, the number and character of patients, the location of those in a more or less helpless state, the number of attendants available for removing them, and the equipment on hand to facilitate removals, such as stretchers, etc. In a well designed fireproof building, such drills need not contemplate removing patients to the outside if each story is properly cut off from those above and below and if extensive floor areas are provided with horizontal exit partitions. Neither should the removal of patients be assumed in drills in a sprinklered, non-fireproof building provided with proper exit facilities and enclosed floor openings. In brief, every hospital should be so constructed and protected as to make it possible and safe for patients to remain within it during a fire. The only patients removed should be those in the ward or area where the fire is burning, and this removal should simply be to another location within the hospital.

The principal function of the fire drill is to supply as quickly as possible a sufficient number of nurses and attendants to quiet the patients, attend to their removal if necessary, and man the first-aid fire-extinguishing equipment and standpipes, pending the arrival of the fire department. In this respect the hospital drill vitally differs from the school fire drill where the complete evacuation of the building is the primary object.

—"Fire Prevention and Protection as Applied to Hospitals," The National Board of Fire Underwriters, 85 John St., New York.

Safety Rules in Serious Fires

1. Make all your plans in advance.
2. Never go to bed without knowing the quickest, safest way to leave the house.
3. Keep the halls, stairs, doors, and fire escapes free from obstruction.
4. Give the alarm promptly; in a crowded room give the alarm quietly and keep the people calm.
5. Know where to find the nearest fire alarm box and study the directions in advance.
6. Wait by the box, if it is outside the burning building, so as to direct the firemen when they appear.
7. If you send a telephone alarm, call the operator and say, "I wish to report a fire," and be sure to give the address.
8. If your door is closed, put your foot against it and open it cautiously. Slam it shut if the fire threatens to rush in.
9. If there is smoke, but no flame, in the hallway, tie a wet cloth around your mouth and nose and crawl on hands and knees if the smoke is dense.
10. Close all doors that you pass in order to keep the fire from spreading.
11. Do not jump from a window except as a last resort. It is better to tear a sheet into strips, tie the strips together into a rope, fasten one end of the rope securely, and slide to the ground.
12. If you have to jump, throw out mattress and bedding to break the fall.
13. Always save life before property. In saving property, take out the most valuable things first.
14. Don't throw breakables from the window.
16. Always keep your head.—From "Safeguarding the Home Against Fire," prepared by the National Board of Fire Underwriters.

The Public Health Nurse for October

Official Magazine of the National Organization for Public Health Nursing

(May be had in combination with the *Journal*)

Follow-up Care of Cardiac Children in the Home, Lucy Porter Sutton, M.D.
Practical Suggestions for Nurses in Industry, W. J. McConnell, M.D.
How to Evaluate Methods of Supervision, Irma E. Reeve.
Health Center Procedure, Lyda T. King.
Problems of School Health, Elma Rood.
Public Health Nursing in Honolulu, S. S. Mathews and A. MacOwan.
Study of Negro Public Health Nursing, N. O. P. H. N. and Rosenwald Fund.

Department of Nursing Education

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The Chemistry Course

What the Student Nurse Should Remember

HARRY C. BIDDLE

Introduction

ONE of the greatest obstacles in the teaching of chemistry from the average textbook is that in many cases the subject matter bears very little relationship to the responsibilities of the nurse, especially when she has had no ward duty. Furthermore, there is considerable variation in the abilities of the students, especially, in schools where only a diploma from an accredited high school is needed for enrollment in the school of nursing.

Purpose of the Investigation

FOR several years the writer has been teaching chemistry to nurses, and during that time many questions have arisen concerning the inclusion of certain topics for the student nurse, as outlined by the Committee on Education of the National League of Nursing Education.

The Committee requires the teaching of some topics which, under any of the accepted objectives of chemistry for nurses, cannot be justified. In most of the schools there is only time available for the teaching of bare essentials, without much opportunity for showing the practical application to the student. This in itself is bad enough, but, what is worse, the average supervisory nurse in the wards does not attempt to carry on the work begun by the chemistry instructor, the consequence of which is that much theory is forgotten and the practical application is not correlated with her classroom teaching.

Informal investigation of the actual experiences of the average nurse seemed to warrant spending less time on some topics and more time on others of greater interest to the nurse. A special lesson, for example, as recommended by the Committee, on the occurrence, preparation, properties, and uses of hydrogen seemed a waste of time, especially so in view of the fact that this information had already been acquired as early as in the junior high school.

The student nurse upon entering the course already knows that hydrogen is a gas, is very light, burns, makes balloons buoyant, and is a component of water and organic material. What few of these facts need repetition would present themselves as related facts when studying certain other subjects. For example, the properties of hydrogen are brought out in the usual laboratory experiments on acids, while the hydrogenation of oils is introduced during the study of fats.

The study of colloidal chemistry and its far-reaching applications, on

the other hand, seemed to demand more time than was called for in the recommended outline. This condition led the writer to make a complete evaluation of the whole of the conventional content of chemistry for nurses.

Method of Investigation

IN making this survey in the state of Ohio, approval and coöperation were secured from Caroline V. McKee, R.N., Chief Examiner of the Nurse Examining Committee of the State Medical Board.

Under the general heading of each of sixteen chapters a list of the most essential chemical facts for the chapter was tentatively selected and organized into statements. These statements (essentials), some two hundred in number, were submitted to the recognized schools of nursing of the state of Ohio.

At each school one instructor and one general duty nurse were asked to rate these statements under the general terms of *very*, *moderately*, and *not* useful, the checking being done while keeping in mind, "What should the student nurse remember as an outcome of the chemistry course?" These three ratings of the varying degree of usefulness were converted into three numerical terms, using three for *very*, two for *moderate*, and one for *not* useful. The index of relative value of each of these topics was then determined by dividing the number of ratings into the total numerical value of each topic. Thus an index of three was the maximum and an index of one was the minimum. This index of relative value was determined for the instructors, for general duty nurses, and for both. From the index of relative value, as obtained from the combined ratings of the statements, the numerical rank of each of the two hundred essentials was made.

These essentials in order of their numerical rank were then converted into decile rank by dividing the 200 essentials into 10 groups. The relative value of each chapter heading was also determined by dividing the number of statements of each chapter into the total of the decile ranks of all the items of that chapter.

Results of the Investigation

TOPICS Which Rank Low.—It is always interesting to find out what material we teach is later considered useful knowledge by our former students. 1.80 was arbitrarily fixed as the point, topics falling below which would be considered for elimination.

A study of the table at the end of this paper reveals that not only would some of the recommended topics be left out of the course, but also practically two entire chapters; namely, "Ionization" and "Equation Writing."

It has always been difficult to explain chemical phenomena, and the conception of the atom (23)[1] from the electrical standpoint is a most helpful theory in explaining such reactions. In view of the fact that this newer conception of the atom provokes interest, gives a concreteness and meaning to chemistry, and that future discussion will resolve itself largely into terms of electricity, it seems as if it should be at least lightly stressed. Nevertheless, it can be easily omitted.

The theory to explain abnormal rise in boiling point, freezing point, and osmotic pressure of electrolytes (72) and the explanation to account for some solutions being stronger than

[1] Figures refer to the number of the statement in the table.

TABLE I—RELATIVE IMPORTANCE OF THE CHAPTER HEADINGS

Chapter Heading	Average Decile Rank	Order of Importance
Some fundamental facts	5.7	10
Definitions and Equations	8.53	15
Oxygen	5.25	8
Water	3.70	2
Solutions	4.81	7
Ionization	10.00	16
Acids	4.00	3
Bases	4.12	5
Salts	5.37	9
Non-metals	6.00	11
Organic chemistry	7.20	14
Hydrocarbons and substitution products	6.82	13
Carbohydrates	4.76	6
Fats	4.10	4
Proteins	6.18	12
Digestion	1.20	1

others (76), probably should not be given much space in a course of this nature, but are necessary information to explain many phenomena which are of vital interest to a nurse.

The study of graphite (117), diamond (118), lamp black (119), and bone black (120), does not have much bearing on the practical work of a nurse, and therefore very little need be taught concerning these materials. Isomerism (132) accounts for the difference in the properties of some substances and clears up a question for some. It is a question if in checking this item all were cognizant of its meaning.

In studying the behavior of several different classes of hydrocarbons (141–144), a general knowledge of the difference in the properties of some compounds can only be gained by understanding the nature of the double and triple bond; that is, we could not explain and account for the greater chemical activity of unsaturated compounds (140) as compared to the saturated (138) if we did not take this into account. The learning of this fact is not an added burden to the student.

In giving the chapter on ionization the lowest value, the question might rightly be asked, "What is its value to the nurse?" Briefly the answer would be, "It explains the peculiar behavior of aqueous solutions of acids, bases, and salts." That statement alone would seem to warrant a higher value.

Comparison of Judgments of Teachers of Chemistry and General Duty Nurses.—In comparing the judgments of teachers of chemistry with choices of general duty nurses, the very surprising and gratifying observation is that, with very few exceptions, there is not much divergence of opinion in regard to the relative value of the two hundred topics. The very few wide divergences which occur are not of seemingly great importance, since they do not involve major topics.

As would be expected wherever theory is involved, with scarcely an exception, the instructor gives a higher

rating. On the other hand, that which is practical is considered of more value by the general duty nurse. These observations might partially be accounted for by the fact that the general duty nurse has largely forgotten the theory underlying many of the applications of chemistry to nursing. She is more keenly alive to the routine which she uses daily in the wards.

The Comparative Importance of the Chapter Headings.—An examination of the average decile rank of sixteen chapters reveals that *digestion* ranks first while *ionization, definitions,* and *equations* rank lowest. In view of the nature of the work of the nurse in the wards, and also since the theory of this work has been stressed in at least two other courses, it is quite natural and logical that digestion should have the highest rating.

On the other hand, the extreme difficulty of teaching *valence* and *equation writing* in such a short period of time, and the limited amount of practical use made of this information, raise the question of the value of including this material. If our students have had an elementary chemistry course as a prerequisite, then we are justified in explaining chemical changes by the use of symbols and formulas; otherwise the effort expended is questionable.

The consensus of opinion of most instructors is that word equations are sufficient for the majority. Nevertheless, it does seem advisable to include this material as an added means of explaining phenomena which otherwise would be very vague. Table I shows the relative importance of the sixteen chapter headings.

Relative Importance of the Essentials of Chemistry for Nurses.—Table II, showing the relative importance of two hundred essentials of chemistry for nurses, is the most important contribution of this study.

By consulting the last column of the table, showing the decile rank, one gets at a glance an idea of the relative importance of each essential fact. For example, in Chapter I, statement 1, concerning the meaning of a chemical change, has a decile rank of three which means that it belongs in the third decile in importance. Column one shows the value assigned to each essential fact by the instructor of chemistry. Column two shows the value assigned to each essential fact by the general duty nurse. Column three shows the value assigned to each essential fact by the combined group of chemistry instructors and general duty nurses. Column four shows the numerical rank assigned to each essential fact by the combined group.

It was determined by arranging the values in column three in numerical order. For example, the first essential fact listed concerning the meaning of a chemical change has the rank of 50, showing that 49 facts are more important, and 150 are less important. Column five, showing the decile rank of each essential fact, is a simpler index of the relative value of each. For example, the first essential fact has a decile rank of 3 which means that at least 20 per cent of the items are more important and 70 per cent of the items are less important.

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY

Essentials	Average value assigned by: (range: 1.00 to 3.00)			Rank	
	Instructor	Nurse	Combined	Numerical	Decile
I. *Some Fundamental Facts*					
1. A chemical change involves a change in composition.	2.82	2.73	2.76	50	3
2. Analysis involves the decomposition of a substance into simpler units; synthesis involves a building-up process.	2.26	2.12	2.18	155	8
3. Matter or energy can be neither created nor destroyed.	2.62	2.71	2.67	69	4
4. The fuel value of foods lies in the amount of heat liberated by a unit weight. The calorie is the unit of heat.	2.84	2.89	2.87	23	2
5. Elements, the simplest form of matter, occur free and combined.	2.33	2.80	2.31	133	7
6. Elements make up the human body and, as salts, affect the nerves, muscles, acidity, and alkalinity.	2.86	2.82	2.84	32	2
7. Compounds are composed of elements.	2.42	2.25	2.32	132	7
8. The composition of a compound never varies.	2.17	1.92	2.02	169	9
9. A mixture differs from a compound by consisting of substances which can be separated by mechanical means.	2.40	2.26	2.32	131	7
10. Only a few elements enter into the composition of the body. Each element in the form of a compound has a use.	2.24	2.19	2.21	148	8
II. *Definitions and Equations*					
11. A molecule is the smallest physical division of matter.	2.42	2.20	2.29	135	7
12. An atom is the smallest indivisible particle of matter.	2.31	2.14	2.21	149	8
13. A symbol is an abbreviation for an element.	2.62	2.58	2.60	85	3
14. A formula represents the composition of a compound.	2.48	2.09	2.25	144	8
15. An equation represents a chemical change.	2.44	2.03	2.20	154	8
16. Knowing the negative valence of an element in a formula, you can determine the positive valence.	2.04	1.61	1.79	184	10
17. By knowing the positive valence in a formula the negative valence can be determined.	1.97	1.53	1.72	189	10
18. A radical is a group of elements acting as a unit.	2.06	1.65	1.82	182	10
19. The formula of a compound can be represented graphically.	2.02	1.77	1.87	176	9

TABLE II—Relative Importance of Two Hundred Essentials of Chemistry—*Continued*

Essentials	Average value assigned by: (range: 1.00 to 3.00)			Rank	
	Instructor	Nurse	Combined	Numerical	Decile
20. By means of symbols an equation can be written to express the direct combination of elements.	2.17	1.87	2.00	172	9
21. Chemical reactions can be expressed by word equations.	2.21	1.77	1.95	173	9
22. With the aid of symbols and formulas the mechanical features of equation writing can be expressed.	2.02	1.60	1.77	186	10
23. The electron theory explains the structure of the atom from an electrical standpoint.	2.73	2.76	2.75	55	3
III. *Oxygen*					
24. Oxygen is very abundant in the air, water, earth's crust, and the human body	2.80	2.87	2.84	29	2
25. Oxygen, besides being important to animal and plant life, produces heat and light.	2.00	2.09	2.05	166	9
26. Oxygen is prepared commercially from liquid air.	2.00	2.09	2.05	166	9
27. Oxygen is prepared in the laboratory by decomposing compounds containing oxygen.	2.24	1.90	2.04	168	9
28. A catalytic agent influences the speed of a chemical reaction.	2.88	2.69	2.77	48	3
29. Oxygen is a colorless, odorless, tasteless gas, slightly soluble in water.	2.62	2.60	2.61	83	5
30. Oxygen is active at high temperature and combines with many elements.	2.55	2.49	2.51	100	5
31. An element combined with oxygen forms an oxide.	2.51	2.47	2.50	102	6
32. Oxidation is the combining of oxygen with a substance.	2.75	2.68	2.72	62	4
33. Oxidation accompanied by heat and light is called combustion.	2.73	2.70	2.72	62	4
34. The starting of a fire without the external application of heat is called spontaneous combustion.	2.62	2.61	2.62	81	5
35. Kindling temperature is the temperature at which there is active combustion.	2.48	2.42	2.45	111	6
36. The match head is a mixture of easily combustible materials.	2.13	2.21	2.18	154	8
37. Fireproof materials are non-oxidizable substances.	2.35	2.32	2.34	128	7
38. Fire extinguishers evolve non-combustible gases.	2.51	2.58	2.55	93	5
39. Oxygen is used in asphyxiation, treatment of disease, and with anesthesias.	2.73	2.93	2.85	23	2

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

40. Commercially pure oxygen is used to aid combustion.	1.75	1.66	1.70	195	10
41. Oxygen in breathing unites with the arterial blood giving it a bright red color.	2.84	2.96	2.91	12	1
42. The injurious effects of bad ventilation are due to high temperature and an abnormal amount of water vapor.	2.84	2.90	2.87	21	2
43. Ozone is a much more active oxidizing agent than oxygen.	2.00	2.17	2.10	164	9
IV. *Water*					
44. Water composes a large part of the soil, foods, and the human body.	2.60	2.77	2.70	68	4
45. Water is the greatest of solvents, and combines with many compounds to form hydrates.	2.71	2.53	2.61	82	5
46. The mineral matter in water consists of common salt and compounds of calcium, magnesium, and iron.	2.68	2.73	2.71	66	4
47. Organic matter in water consists of products derived from the decomposition of plant and animal matter.	2.57	2.66	2.62	80	4
48. Analysis of water may involve either a mineral or sanitary analysis.	2.44	2.58	2.52	99	5
49. Distillation consists in the evaporating and condensing of the vapor.	2.55	2.74	2.66	73	4
50. Boiling kills germs but does not remove any foreign matter.	2.95	2.96	2.96	6	1
51. Commercially, water is purified for drinking purposes by the slow sand filter, rapid sand filter, and chlorination methods.	2.73	2.69	2.71	65	4
52. Hard water is objectionable in washing and cooking.	2.53	2.61	2.58	90	5
53. Physiologically, water is important in facilitating chemical action, conveying and eliminating waste products, keeping surfaces moist, etc.	2.97	2.96	2.96	5	1
V. *Solutions*					
54. A solution is a homogeneous mixture of a solute and a solvent, capable of passing through a filter.	2.68	2.76	2.71	64	4
55. The solubility of solids generally increases with rise in temperature.	2.91	2.79	2.84	30	2
56. A solution may be diluted, concentrated, saturated, or supersaturated.	2.84	2.88	2.87	22	2
57. Osmosis is the passage of a liquid through a semipermeable membrane.	2.77	2.69	2.73	59	3

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

Essentials	Average value assigned by: (range: 1.00 to 3.00)			Rank	
	Instructor	Nurse	Combined	Numerical	Decile
58. An isotonic saline solution is one of equal osmotic pressure with that of the blood.	2.95	2.95	2.95	7	1
59. A saline solution may be hypertonic or hypotonic to the blood and result in plasmolysis or hemolysis.	2.95	2.71	2.82	37	2
60. The solubility of solids can be hastened by powdering, stirring, and heating.	2.86	2.79	2.82	36	2
61. Solution is very important in hastening chemical action; *e. g.*, the digestion of foods.	2.86	2.80	2.83	35	2
62. The boiling point and freezing point of solutions is affected by the molecular concentration of the solute.	2.40	2.47	2.44	115	6
63. A colloidal solution consists of particles held in suspension, particles too large for a true molecular dispersion.	2.31	2.17	2.23	146	8
64. Colloidal particles are small enough to pass through ordinary filter paper but not through a membrane.	2.55	2.28	2.37	125	7
65. The degree of dispersion of colloids determines the color of many solutions.	1.97	1.72	1.83	180	9
66. Colloids are electrically charged particles in solution and are often used to disperse some liquids and thereby aid in solution.	2.15	2.06	2.11	163	9
67. Colloids adsorb dissolved substances from solution; *e. g.*, the soft cartilage adsorption of calcium compounds.	2.82	2.20	2.25	143	8
68. The tissues of the body are hydrated gels.	2.16	2.07	2.12	162	9
69. An emulsion is a colloidal dispersion of one liquid in another liquid; *e. g.*, oil emulsions.	2.80	2.73	2.75	53	3
VI. *Ionization*					
70. Electrolytes are acids, bases, and salts, which in water solutions conduct the electric current.	1.91	1.74	1.81	183	10
71. The decomposing of a substance by the electric current is called electrolysis.	1.77	1.77	1.77	185	10
72. Electrolytes as compared to non-electrolytes produce an abnormal rise in the osmotic pressure.	1.75	1.87	1.82	181	10

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

73. The ionic theory states that an electrolyte in water dissociates in atoms or radicals which consist of electrically charged particles called ions.	1.73	1.77	1.75	188	10
74. The properties of electrolytes depend upon the number of ions present.	1.73	1.66	1.69	196	10
75. Dilution produces greater ionization.	1.75	1.66	1.70	194	10
76. Strength of electrolytes in solution depends upon the degree of ionization.	1.82	1.61	1.70	193	10
VII. *Acids*					
77. Acids are either inorganic or organic.	2.77	2.74	2.75	54	3
78. Acids have a sour taste, turn litmus paper pink, act on metals, bases, carbonates, and the tissues.	2.86	2.76	2.80	41	3
79. An acid furnishes hydrogen ions in solution.	2.06	2.03	2.04	167	9
80. The naming of inorganic acids depends upon whether they are binary or ternary.	2.04	1.98	2.00	171	9
81. Hydrochloric acid has several important functions in the stomach.	2.95	2.96	2.96	4	1
82. Hypochlorous acid is the acid in Dakin's solution.	2.84	2.84	2.84	31	2
83. Nitric, sulphuric, and hydrochloric acid are the most important commercial acids.	2.80	2.76	2.77	47	3
84. A few organic acids only, as boric, picric, tannic, citric, etc., are important acids to the nurse.	2.75	2.76	2.75	52	3
85. Organic acids in metabolism account for the alkalinity of the blood.	2.86	2.71	2.77	49	3
VIII. *Bases*					
86. Bases turn litmus blue, act on acids and the tissues.	2.82	2.77	2.79	45	3
87. The alkaline fluids of the body are the intestinal fluids and the blood.	2.91	2.83	2.87	20	1
88. A base furnishes hydroxide ions in solutions.	2.35	2.09	2.20	150	8
89. Sodium hydroxide (lye) is corrosive and disintegrates organic matter.	2.51	2.36	2.42	117	6
90. A solution of slaked lime is called lime water, and is used to overcome acidity of the stomach.	2.77	2.68	2.72	61	4
91. Ammonium hydroxide is used for cleaning, to stimulate respiration, and circulation.	2.82	2.77	2.79	44	3
92. A reaction of a salt and water to form a base and an acid is called hydrolysis.	2.57	2.31	2.42	116	6

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

Essentials	Average value assigned by: (range: 1.00 to 3.00)			Rank	
	Instructor	Nurse	Combined	Numerical	Decile
93. Alkalies are base-forming substances; *e. g.*, sodium hydrogen, carbonate.	2.86	2.80	2.83	34	2
IX. *Salts*					
94. The reaction of the hydrogen ion of an acid with the hydroxide ion of a base to form water is called neutralization.	2.27	2.06	2.14	157	8
95. Salts, among other methods, can be prepared by neutralization, by the action of an acid with a metal, and by a salt with a salt.	2.48	2.12	2.21	147	8
96. Some typical salts of importance to the nurse are NaCl, HgCl, $HgCl_2$, $MgSO_4$, $CuSO_4$ KNO_3, $AgNO_3$, and $BiONO_3$.	2.69	2.20	2.58	89	5
97. Salts are either normal, acid, or basic.	2.40	2.41	2.40	120	6
98. Salts are named in accordance with the names of the acids from which the salts are derived.	2.95	2.33	2.59	88	5
99. Salts have general, besides specific, functions in the body.	2.95	2.87	2.90	15	1
100. Salts affect the cells; *e. g.*, osmosis, diffusion.	2.86	2.74	2.79	43	3
101. Alkaloidal salts are bitter, poisonous, nitrogenous compounds which are much used in medicine; *e. g.*, quinine sulphate.	2.44	2.31	2.37	124	7
X. *Non-Metals*					
102. Metals differ in their properties from non-metals.	2.26	2.08	2.16	156	8
103. Nitrogen occurs in the air and in proteins.	2.84	2.55	2.67	72	4
104. Nitrogen is only active at high temperatures.	2.28	2.25	2.26	142	8
105. Nitrogen is essential to plant and animal life.	2.57	2.36	2.45	114	6
106. Nitrogen diminishes the intensity of oxygen and enriches the soil.	2.57	2.12	2.31	134	7
107. Ammonia gas is used in refrigeration.	2.62	2.12	2.33	130	7
108. Salts of ammonia are heart stimulants and expectorants.	2.95	2.84	2.96	24	2
109. Nitrous oxide is an anesthetic.	2.86	2.88	2.87	19	1
110. Amino acids are the end products of the digestion of proteins.	2.82	2.76	2.78	46	3
111. Chlorin is used for disinfection.	2.93	2.79	2.85	28	2
112. Bromin salts are used as sedatives.	2.85	2.84	2.85	27	2

TABLE II—Relative Importance of Two Hundred Essentials of Chemistry—*Continued*

113. Iodin has antiseptic properties.	2.74	2.90	2.84	33	2
114. Sulphur is used in certain skin diseases.	2.60	2.47	2.53	97	5
115. Phosphorus exists in the bones, teeth, and tissues as compounds.	2.43	2.59	2.53	96	5
116. Coal exists in several varieties representing different stages in the decomposition of vegetable matter.	2.18	2.01	2.06	165	9
117. Graphite, an allotropic form of carbon, is a lubricant.	1.63	1.76	1.71	192	10
118. The diamond is used commercially for drilling, polishing, and grinding.	1.45	1.66	1.58	200	10
119. Lamp black is used in black paints and inks.	1.45	1.60	1.54	201	11
120. Bone black is used to remove colors from certain liquids.	1.84	1.47	1.62	198	10
121. Charcoal, an amorphous form of carbon, is a fuel and absorbent.	1.88	1.80	1.84	179	9
122. Coke is mostly used as a fuel.	1.88	1.80	1.84	178	9
123. Carbon at high temperature unites with oxygen and metals.	2.57	2.19	2.34	120	7
124. Carbon dioxid gas stimulates respiration, and is used in fire extinguishers.	2.52	2.74	2.65	76	4
125. Plants absorb carbon dioxid by a process called photosynthesis.	2.63	2.42	2.51	101	6
126. Carbon monoxid, a poisonous gas is formed as the result of imperfect combustion of carbon.	2.84	2.66	2.74	58	3
XI. *Organic Chemistry*					
127. Organic chemistry deals with a study of carbon compounds.	2.60	2.44	2.50	105	6
128. Many organic medicines such as dyes and perfumes, are synthesized by the chemist.	2.51	2.36	2.42	119	6
129. Organic compounds differ from inorganic compounds in being combustible, poor electrolytes, not very active or soluble.	2.22	2.33	2.28	137	7
130. Chemistry is important because of its close relationship to medicine.	2.62	2.54	2.57	91	5
131. Organic compounds are derived from both the plant and animal kingdom.	2.55	2.46	2.50	103	10
132. Isomers are compounds of the same percentage composition, but differ in properties due to the arrangement of the atoms.	1.95	1.61	1.75	187	6
133. Carbon atoms can unite in the ring and chain form.	2.02	1.82	1.90	175	9

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

Essentials	Average value assigned by: (range: 1.00 to 3.00)			Rank	
	Instructor	Nurse	Combined	Numerical	Decile
134. Organic compounds are classified as oxids, acids, ethers, alcohols, hydrocarbons, aldehydes, ketones, amines, carbohydrates, fats, and proteins.	2.48	2.34	2.40	122	7
135. Only a small part of the organic molecule, called the characteristic group, enters into a chemical reaction.	2.05	1.71	1.85	177	9
136. The object in studying organic compounds is to learn general facts of classes of compounds and the relation between them.	2.44	2.16	2.27	140	7
XII. *Hydrocarbons and Substitution Products*					
137. Hydrocarbons are classified according to the proportion of carbon to hydrogen; *e. g.*, methane, ethylene, acetylene and benzene series.	2.08	1.76	1.90	174	9
138. Hydrocarbons incapable of combining with more hydrogen are saturated; *e. g.*, the methane series.	1.84	1.60	1.71	191	10
139. Substitution products are the result of replacing the hydrogen by other elements or radicals.	1.93	1.56	1.71	190	10
140. Hydrocarbons are unsaturated due to the double or triple bond.	1.71	1.52	1.61	199	10
141. Methane is the result of the decomposition of organic matter, and natural gas is mostly methane.	2.26	2.25	2.26	141	8
142. Ethylene is an anesthetic.	2.46	2.38	2.42	118	6
143. Acetylene is a source of great heat and light.	2.24	2.02	2.12	161	9
144. Benzene is a solvent.	2.17	2.36	2.29	136	7
145. An alcohol is a hydroxid substitution product of a hydrocarbon.	2.48	2.56	2.53	95	5
146. Methyl alcohol is poisonous and is used as a solvent.	2.53	2.64	2.60	87	5
147. Ethyl alcohol is a solvent, a rubbing agent, and is used to prepare many medicinal compounds.	2.73	2.67	2.73	60	3
148. Glycerin is used in many pharmaceutical preparations.	2.84	2.76	2.79	42	3
149. Phenol is an antiseptic.	2.69	2.79	2.75	56	3
150. Ether is an anesthetic.	2.20	2.67	2.48	110	6
151. An aldehyd is an oxidation product of an alcohol, and is a powerful reducing agent.	2.44	1.88	2.12	160	8

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

152. Ketones are incomplete oxidation products of alcohols, acetone being the most important.	2.44	2.52	2.49	108	6
153. Organic acids are weak as compared to inorganic acids.	2.44	2.06	2.20	153	8
XIII. *Carbohydrates*					
154. Carbohydrates occur mostly in the plant kingdom.	2.80	2.65	2.71	67	4
155. Carbohydrates are compounds composed of carbon, hydrogen, and oxygen. Their function is to produce energy.	2.84	2.87	2.85	26	2
156. The carbohydrates are classified according to the number of saccharide groups in the molecule.	2.62	2.25	2.40	121	7
157. The carbohydrates vary in their solubility and digestibility.	2.55	2.65	2.61	84	5
158. The carbohydrates contain in their molecules the aldehyd or ketone group, along with alcoholic groups.	2.00	2.00	2.00	170	9
159. Benedict's test for sugar is based upon the reducing property of the aldehyd or ketone group.	2.28	2.27	2.27	139	7
160. Hydrolysis of the di- and polysaccharides takes place in the presence of certain enzymes.	2.71	2.38	2.52	98	5
161. Fermentation is produced by the bacteria, yeasts, or molds.	2.73	2.78	2.75	51	3
162. Oxidation produces carbon dioxide, water, and energy.	2.80	2.81	2.81	40	2
163. Dextrose is found in the blood and diabetic urine.	2.64	2.70	2.67	70	4
164. Sucrose is the ordinary table sugar found in many fruits and plants.	2.64	2.73	2.69	69	4
165. Lactose is the sugar occurring in milk.	2.60	2.68	2.64	78	4
166. Maltose sugar is found in germinating grain, and is present in many malted preparations.	2.57	2.70	2.65	77	4
167. Starch unless heated is not digestible. Dextrin, as the result of heating dry starch, is digestible.	2.57	2.73	2.66	75	4
168. Cellulose forms the fibrous portion of plants. In foods its function is to produce peristalsis.	2.75	2.62	2.67	71	4
169. From cellulose, collodion and celluloid are made.	2.08	2.33	2.23	145	8
170. Glycogen or animal starch is stored up in the liver as a reserve supply of energy.	2.55	2.70	2.63	79	4

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

Essentials	Average value assigned by: (range: 1.00 to 3.00)			Rank	
	Instructor	Nurse	Combined	Numerical	Decile
XIV. *Fats*					
171. Fats occur in the organs and tissues of animals; in seeds, roots, and fruits of plants.	2.86	2.77	2.81	39	2
172. Fats are composed of the same elements as found in carbohydrates, but contain a smaller amount of oxygen.	2.41	2.55	2.50	104	6
173. Fats are soluble in ether, benzene, hot alcohol; and are readily oxidized and saponified.	2.46	2.52	2.49	106	6
174. Fats are glyceryl salts of fatty acids.	2.33	2.36	2.35	126	7
175. Soaps are metallic salts of the fatty acids, olein, palmitin, and stearin, and form alkaline colloidal solutions.	2.64	2.68	2.66	74	4
176. Fats decompose upon heating acrolein, and are readily oxidized and saponified.	2.20	2.20	2.20	152	8
177. Soaps remove dirt by emulsifying fat, and forming colloids which adsorb the dirt.	2.62	2.52	2.56	92	5
178. Fats serve as a fuel, an insulator to injury, and as a constituent of protoplasm.	2.91	2.93	2.92	8	1
179. Fats in the course of digestion are emulsified by the bile and saponified by pancreatic lipase.	2.93	2.90	2.91	10	1
180. In the lymph the fatty acids and glycerin are synthesized to form body fats.	2.93	2.88	2.90	14	1
XV. *Proteins*					
181. Proteins occur in the fluids and tissues; they contain the element nitrogen, and function as a tissue builder.	2.71	2.88	2.81	38	2
182. Proteins are combinations of amino acids.	2.33	2.52	2.45	112	6
183. Some proteins are soluble in plain water, others only in salt water, acids, or alkalies.	2.33	2.53	2.45	113	6
184. Proteins form colloidal solutions.	2.33	2.33	2.33	129	7
185. Proteins can be precipitated by heat, salts of heavy metals, alcohol, and acids.	2.32	2.41	2.37	123	7
186. Upon hydrolysis, proteins yield proteoses, peptones, peptides and amino acids.	2.61	2.37	2.48	109	6
187. The Biuret test for protein consists in producing a violet color when treated with an alkaline copper sulphate solution.	2.19	2.11	2.13	158	8

TABLE II—RELATIVE IMPORTANCE OF TWO HUNDRED ESSENTIALS OF CHEMISTRY—*Continued*

188. The simple proteins hydrolyze into amino acids.	2.49	2.47	2.49	107	6
189. The conjugated proteins are the simple proteins combined with some non-protein substance.	2.13	2.11	2.13	159	8
190. The derived proteins are obtained from the other two classes of proteins by the action of acids, alkalies, heat, or enzymes.	2.29	2.26	2.27	138	7
191. The amino acids are synthesized in the tissues to form body proteins.	2.64	2.47	2.54	94	5
XVI. *Digestion*					
192. Foods supply energy, repair tissue, and provide for growth.	2.95	3.00	2.98	2	1
193. All colloidal food before absorption must undergo a chemical change.	2.82	2.68	2.74	57	3
194. Metabolism includes all chemical action in the body after food is absorbed and is both constructive and destructive.	2.95	3.00	2.98	1	1
195. Proper digestion demands both physical and chemical changes.	2.95	2.98	2.97	3	1
196. Enzymes are catalyzers in the body which have certain functions and characteristics.	2.95	2.90	2.92	9	1
197. Ptyalin or salivary amylase is the principal enzyme of the saliva.	2.93	2.88	2.90	13	1
198. The principal enzyme of the gastric juice is pepsin which hydrolyzes the proteins.	2.93	2.90	2.91	11	1
199. Trypsin of the pancreatic juice acts on proteins.	2.91	2.87	2.87	17	1
200. Erepsin of the intestinal juice further hydrolyzes the proteoses and peptones.	2.86	2.90	2.88	18	1
201. Digestion in the lower colon is produced to some extent by the fermentative and putrifying bacteria.	2.86	2.92	2.98	6	1

Greetings to the New State League in Tennessee

WE have great pleasure in welcoming to the company of State Leagues of Nursing Education the new one in Tennessee, which has just completed its organization this summer. May it prosper long, and be of great assistance to the nursing education in the state. State Leagues can do so much in leading programs of study and institutes, making possible the coöperation of educational authorities in the use of educational facilities, profiting by the visits of educators to the state, bringing out latent capabilities in young instructors, attracting good people to nursing education, etc., etc., ad infinitum, that we are rejoiced when there is a State League formed. An organized body can coördinate the work of individuals, and we are happy that the new League is now ready to utilize the opportunities of Tennessee as never before.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Red Cross Contribution to Nurse Education

NURSE educators and others have quite generally conceded that the Red Cross, through adhering to a high as well as stable standard for enrollment in its Nursing Service, has made a notable contribution toward improved educational standards, and in the final analysis to the better care of the sick as well as in the preventive field. This is not only true as far as requirements for enrollment are concerned, but also where the selection and appointment of Red Cross public health nurses, or Red Cross nurse teachers of its courses in Home Hygiene and Care of the Sick, is concerned, as applicants for any type of Red Cross work must meet Red Cross standards.

It is a matter of daily occurrence to receive communications from individuals, national and international organizations seeking advice and assistance on questions concerning nurse education, organization of schools of nursing and public health nursing services as well as methods employed in developing and maintaining our enrollment of nurses.

American Red Cross nurses may be found in practically every country of the world. Though they may not be employed by the American Red Cross, many have been selected or recommended by the organization. Annual reports from these widely distributed nurses are promptly returned and, like their letters, indicate their devotion to the ideals of the Red Cross. In order that the Red Cross may continue to merit the confidence and respect of the public as well as to continue its mission of upholding educational standards, opportunities for safeguarding its standards are constantly considered.

The National Committee on Red Cross Nursing Service, at its last meeting, recommended certain modifications of evaluating the length and contents of affiliating and postgraduate courses for applicants from schools falling below the minimum standard for enrollment. As a result a more flexible schedule was adopted. This appeared in the Red Cross Department in the September issue of the *American Journal of Nursing* and is already attracting attention.

The list of accredited schools published by the American Nurses' Association is invaluable to the Red Cross and has been consistently used in checking applications from graduate nurses. So far it is almost the only source of information, although checking with state boards of examiners and schools is employed.

In the past, if an accredited school stated it had a daily average of fifty or more patients and offered experience in medical, surgical, and obstetrical nursing, as well as pediatrics, the Red Cross usually accepted this as adequate experience, provided the candidate from such was also a member of the American Nurses' Association, registered, physically fit, and vouched for by the school from which she graduated, as well as her alumnae.

Such a candidate was usually enrolled without further question.

However, it does not always follow that the contents of a listed course would suffice to prepare adequately a nurse for Red Cross enrollment. For example, the graduates for several years from a school which appeared to meet all Red Cross requirements were enrolled. A director of nursing education for the state was secured. Her first visit to this particular school revealed the fact that only seven beds for children were maintained, these largely used for surgical cases—mainly adenoids and tonsils. A difficult question immediately arose. Should the Red Cross continue to enroll nurses because it had in the past, or should it refuse to do so on information received from the Director of Nursing? If it refused, an applicant would naturally feel that she was being discriminated against because graduates in the past had been accepted. The trustees of the institution also took up the matter. They saw no reason for a reversal of position on the part of the Red Cross. If the older graduates were considered eligible for enrollment, why not those of more recent years? Quite overlooking the point that they had, unintentionally, no doubt, misled the Red Cross by claiming through the accredited lists a service—because they have seven cribs—that in the final analysis fell far short of providing an adequate preparation in pediatrics. A nurse from such a school wishing to enter the Red Cross Rural Public Health Nursing Service, where a sound experience in diseases of children is absolutely essential, would be found inadequately prepared. In such delicate questions as this the advice of a National Committee is invaluable. Having among its members leaders in nurse education and public health nursing, the best type of advice is available. In this particular question it has been decided, upon the advice of this Committee, that the training in pediatrics is inadequate and that recent graduates should not be accepted unless they had had the advantage of a three months' affiliation in pediatrics in a well established institution. In such ways as this the Red Cross exercises far reaching influence upon educational standards. Many illustrations could be given but this will suffice to prove the point.

Nursing Field Representatives for Western Pennsylvania, Maryland, and California

MARIE PETERSON, graduate of the Illinois Training School for Nurses, Chicago, Illinois, has been appointed Nursing Field Representative for Western Pennsylvania and part of Maryland. Calista Crown, graduate of Peter Bent Brigham Hospital School of Nursing, Boston, Massachusetts, has been appointed Nursing Field Representative for California. Both of these appointees have served as Chapter nurses, teaching Home Hygiene and Care of the Sick and engaged in public health nursing. They, therefore, come well qualified for this wider Red Cross responsibility.

Enrollments Annulled

THE enrollments of the following Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Anna Hudak, Mrs. Rose Krueger Hoffman, Electa Jane Hughes, Elizabeth Catherine Hughes, Helena I. Hughes, Margaret Monica Hughes, Mrs. Beatrice A. Huntington, *née* Hill, Irene Anastasia Hurley, Emma Hustad, Pearl Kathryn Huston, Ethel Mae Ikins, Helen Ingles, Alta Maebelle Itter, Beatrice M. Jackson, Mabel L. Jarrett, Mrs. John Jay, *née* Eunice Ann Fuller.

Student Nurses' Page

What To Do in Case of Fire

FLORENCE VIVIAN BENZING

Deaconess Hospital School for Nurses, Cincinnati, Ohio

THE Deaconess Hospital, in Cincinnati, is composed of two parts, one old and the other new. The new building is of fire-resisting construction, but the older part is in the style of thirty years ago, with wood floors and trim which would readily burn if a blaze were to gain headway. In this older section, however, every precaution has been taken to keep fire from spreading, and the stairways have been enclosed to prevent smoke from gaining access to other floors. Chemical fire extinguishers are placed at convenient points, a larger number of them in the old building, where the need is greater. Fire hose is also at hand, and may be put into play by turning the valve which releases the water. Typed instructions, telling what to do in case of fire, hang on the wall near each length of hose, and all students are expected to become familiar with these instructions.

If a fire should occur, the supervisor would assume command. In her absence this duty would fall to the senior nurse. The first thing to be done is to notify the telephone operator as to the exact location of the fire. The operator, in turn, will report the fire to the city fire department. If, for any reason, there is not an immediate reply from the switchboard, a student should go at once to the nearest fire-alarm box, which is just across Clifton Avenue, and there turn in the alarm.

After a fire has been reported, in the old building, the students should begin moving patients into the new, or fireproof, part. Patients farthest from the point of safety; that is, the place where the new hall meets the old, should be taken out first. Beds can be wheeled through the doorway, except in one wing, and here patients must be transferred to stretchers and wheelchairs, or carried out in the arms. While some students are moving patients, others should use the chemical fire extinguishers and the hose.

When all the patients have been taken out, the fireproof curtain between the two buildings should be dropped, to shut off the burning section from the part to which the patients have been removed. This curtain is held in place by a chain, having one fusible link and will, if left up until the heat becomes sufficiently intense, drop of itself, through the melting of the link.

If fire breaks out in the new building, the construction there simplifies the difficulty of finding safety for patients. Nurses should roll the beds out of the room in which the first has started, into another room, and should use the fire extinguishers. In this

part of the hospital each room constitutes a fire-resisting unit.

It is of great importance for a nurse to assure her patients that they are being protected, and so lessen, if possible, the sense of anxiety and fear which is the inevitable result of helplessness in a time of danger. Above all, nurses must remain calm, so as to act wisely, as well as quickly, in case of fire.

A Changed Point of View

UPON arriving at Sheppard and Pratt Hospital (for mental patients) I had no definite idea as to what was in store for me. After hearing the discussions of the different girls who had already been here, I was somewhat bewildered. The assurance of "Oh, you will like the work; I was just crazy about it," was a consolation which was handed me often, when Sheppard was mentioned; but upon varying this statement with some of the crude tales told me, I was somewhat inclined to wonder just how well I should like the work and how I should get along in my course.

I had pictured a hospital of the most remote type, with few activities other than raving and crying, where the hardest job for the nurse was to keep out of the way of flying furniture and to duck the kicks and blows of outraged patients. Therefore, of course I had a decided feeling of fear and curiosity as well as the desire to learn for myself just why mentally ill patients were so vastly different from normal people.

My few months here at Sheppard and Pratt Hospital have changed my opinion of mentally ill patients. They no longer are a curiosity to me, but are regarded as unfortunate beings who are ill because of some difficulty to which they have not been able to adjust themselves. My course has given me a keener insight and a more sympathetic understanding. It has taught me the importance of keen observation of small details; the necessity of keeping cool-tempered; of keeping quiet when angry; of trying to avoid wrong impressions; of being alert and prepared for emergency at any time; and it has changed my feeling of fear to one of interest and determination to learn more.

A Freshman's Tribute

A SENIOR stood on a railroad track,
The train was coming fast;
The train stepped off the railroad track
To let the senior pass.

Progress Notes, Atlantic City Hospital.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

The Trials of a Private Duty Nurse

BEHIND the scenes in a play what a strange story of human life is depicted. So it is in the life of each private duty nurse, whether she is wearing a fur coat, or is thinly clad in silk, or is arrayed in her starched white uniform, one can read a story in each countenance, for each one is carrying her burdens of life; bravely and silently journeying onward. She is depending upon the registry for her calls for duty, in fact for her very subsistence in life. Is it any wonder she calls up almost daily to inquire about the prospects for a case, and where she is on that great list of nurses? It would seem under such important circumstances as those surrounding the private duty nurse, that merely placing nurses in order on the list is not sufficient; each school should have a different color for indexing the names of their graduates on the registry. The date the nurse registers in should be written down over her name. At the close of each month a record of the number of days each nurse has been on duty should be presented to the Board of Directors of the registry. All registry matters should be regarded as confidential, just as we regard our patients' affairs confidential and guard their secrets. We cannot help it if we came into this world with red hair, or were not endowed with a beautiful countenance and a fine personality, we were able to meet the educational requirements and enter our Alma Mater, and graduate and pass the state board examination; and now that we have joined the greatest army of nurses in the world, the private duty ranks, we wish to be ethical and dignified and worthy of the place we have chosen in the nursing profession. In many instances, even in large cities, and where civilization has made a marked advancement along every line, private duty nurses are working twenty and often thirty-six and forty hours. The great railroad officials of our land tell us a man is unfit for duty after sixteen hours of continuous duty, and he is sent home, because he is responsible for human life. How much more are we responsible, then, dealing with sick humanity, and administering drugs; often dealing with difficult cases, where one symptom unobserved might mean the loss of a human life. I am surprised that the medical profession, having made such remarkable strides in recent years, will permit such conditions to exist. We should follow the example set by California, shorter hours and less pay, giving better service to humanity, knowing we are benefitting our patients and are helping our sister nurses in many lines of work. Men are working shorter hours in order that their fellow-men may make a living. Surely in a profession which represents the highest of all ideals, selfishness should not enter.

"ONE OF THEM"

Oklahoma

Information Wanted

INFORMATION is urgently desired as to the present address of Kathryn N. Allen, who graduated in 1911 from the Washington Hospital, Pennsylvania, and who served in France during the war. She was also a Red Cross nurse. It is thought she may have entered a hospital in France, as a Sister or nun. One of Miss Allen's sisters is hopelessly ill and is constantly longing for news of her. She is asked to write to 1379 Belle Avenue, Lakewood, Ohio. Anyone having information about her is also asked to communicate with Mrs. Edna Rinker at the same address.

A Schedule for Special Duty

IN the March issue of the *American Journal of Nursing*, "Suggestive Plans for Specials" was published, with the statement that Seaside Hospital, Long Beach, California, had adopted plans and, at the time of Miss Geister's visit to Long Beach, District No. 18 had the agreement in writing from the Board of Seaside Hospital that said plans would be put into effect shortly after the first of the year. However, the wave of financial depression descended and it was thought best to delay putting the plans into effect. Instead, a ten and one-half hour day was inaugurated on May 1, and has been in operation since that time at Seaside Hospital and Community Hospital and, when feasible, in homes.

SCHEDULE

Day nurse: on duty, 7 a.m.; off duty, 5.30 p.m.

Night nurse: on duty, 8.30 p.m.; off duty, 7 a.m.

Relief nurse: 5.30 p.m. to 8.30 p.m.

It is permissable for a patient desiring continuous care to have eight-hour nursing care; the fees for this schedule are $6 per day, without reference to the length of day, with the exception of alcoholic cases, and quarantine cases, which are $8 and $7 respectively. This schedule has been quite successful, and the nurses find they are relieved of much fatigue. It is not what we hoped for and still hope for. We have eliminated the sliding scale which permits nurses to remain on twelve hours and charge extra for it; if they remain, it is for the same as the ten and one-half hour day.

F. C.

California

A Life-Saving Device Needed

I HAVE recently passed through the bitterest experience of my life in losing a year-old grandchild. She was strangled by catching her head under the lid of a screened bed. The need of an automatic lid fastener for such beds is imperative, and I have taken every means I can think of to urge this point. I have written to manufacturers of beds and to child specialists and I am now writing you, hoping that it may be possible to publish at least a word of caution in your *Journal*. The need for an *automatic* fastener seems to me very great—one which would securely fasten the lid whether the nurse remembered it or not.

G. B. M.

California

Too Many Nurses in West Palm Beach

FLORIDA STATE NURSES' ASSOCIATION, District No. 9, wishes to advise the nurses that there is a sufficient number of local nurses in the Palm Beaches to care for all needs for the coming season.

M. L. B.

Florida

And in Tampa

DISTRICT IV, Florida State Nurses' Association, Tampa, Florida, does not wish to be inhospitable, but deems it wise to advise nurses planning to come to Tampa this winter to do private duty, that unemployment here is a serious problem in that branch of nursing, and that there are many local nurses now finding it hard to make a living.

M. D. T.

Florida

And in St. Petersburg

WARNING to nurses not to come to St. Petersburg; too many here now. Under the new law an occupational tax of $15 a year is necessary in order to be eligible to nurse in this state.

I. V. R.

Florida

And in Tucson

PLEASE do not come to Tucson expecting to find work. Our registrar reports only six weeks of fairly good work last winter. There were usually a third of those on the registry on call and now three-fifths of the nurses are waiting for work.

N. J. C.

Arizona

Journals *Wanted*

THE Michigan State Nurses' Association desires the following copies of the *Journal* (Address Olive Sewall, Room 206, Capitol Savings Bldg., Lansing, Mich.): 1900, complete; 1901, January through April, June through September; 1902 through 1906, complete; 1907, January through May, July through September; 1908 through 1909, complete; 1910, January through August, October and December; 1911, January, April through June, August through December; 1912, complete; 1913, February through June, August and September; 1914, February through August, October and November; 1915, complete; 1916, January through July, October; 1917, February through April, June through September, November and December; 1918, February through December.

Celia Cranz, City Hospital, Akron, Ohio, needs copies of the *Journal* for 1915, June; 1916, February, September. She will pay for the magazines and postage.

Journals *on Hand*

WINIFRED C. CAMPBELL, South Side Unit, Youngstown Hospital, Youngstown, Ohio, will give away for the price of postage: 1922, August, October, December; 1923, all but January and February, 1924, all but January; 1926, complete; 1927, February; 1928, May and August; 1929, July.

Many old copies of the *Journal* from 1919, on, have been given to the *Journal* by the W. B. Saunders Company. Copies needed may be had, while they last, by sending postage, ten cents a copy, to Mr. W. S. Slack, Drexel Building, Philadelphia, Pa.

Miscellany

Sophie Mannerheim

Excerpts from a Memoir by Berta Edelfelt

FEW people of her distinction have been as unassuming as Sophie Mannerheim, though it would be difficult to find any name more worthy to appear in the Finnish peerage, if the word "peer" be taken in its highest sense of a refinement which is the product of centuries of cultivation and long years of inherited culture, both of mind and body.

. . . . .

St. Martin won his sainthood by giving half his cloak to a beggar; Sophie Mannerheim would have given not only the whole cloak, but all her worldly possessions and her throbbing, loving heart, the peace of her nights and the calm of her days if anyone were in need. When she came upon some tragic incident in life, she never said, "How terrible to see so much distress," without adding immediately, "What can be done to help? What can I do?" And in the same instant a plan was ready and in the next it was carried into effect, and very often help found. Circumstances brought her into contact with literally thousands of people of all ranks, many of whom she came to know intimately.

Eva Charlotta Lovissa Sofia Mannerheim, daughter of Count Carl Robert Mannerheim and his wife Helene, *née* von Julin, was born on December 21, 1863, in Helsingfors, but she spent her childhood on the family estate at Willnäs, in the west of Finland. She loved this place; how often used she to speak of the old grey stone mansion, with its unpapered rooms hung with canvas on which were painted pictures of the King's Garden in Stockholm. . . . Then came schooldays in Stockholm, where she had relations who received her with open arms, an aunt who had married the North Pole explorer, Adolf Erik Nordenskiöld, and another, the wife of Professor Christian Lovén.

When she was twenty-two, Sophie Mannerheim came back to Finland. It was at the time when Ibsen and Kielland were at the height of their fame. The old ideas were tottering and girls belonging to the highest families in the land were going out into the world, if not like Nora to educate themselves, at any rate to carve out an independent career. It caused a certain amount of sensation when Count Mannerheim's daughter took a post first in the Statistical Department of the Customs Office and later as cashier in a large bank. But emancipation was in the air and even the older generation admitted that she had courage, and Sophie Mannerheim soon found a host of admiring friends among her admiring workers, while her capability won for her the unreserved respect of her chiefs.

When she left the bank she travelled abroad with Mrs. Karamsin, wife of Colonel Karamsin, a relation and old friend of the family, visiting so far distant as in Portugal and spending a season in Berlin, where she found more friends and other members of the family in diplomatic circles, who were delighted to receive her. She then came home and married Sir (Kammerherre) Hjalmar Linder and went to live on the beautiful old estate of Laxpojo, her new home. But, after a few years, the marriage was dissolved and the day, in the spring of 1899, when Sophie Mannerheim entered St. Thomas's Hospital, London, as a student nurse was probably the turning point in her life.

. . . . .

In 1902 she came home to Finland, lived for a little while in Borgå, served as a nurse in the Högsands Sanatorium for scrofulous children in the summer of 1903, and in 1904, with much hesitation, became matron at the Surgical Hospital in Helsingfors.

When she started her duties she found that, compared with St. Thomas's Hospital, much of the administration and organization was unsatisfactory and out of date and, in her eager enthusiasm, at once wanted to institute sweeping reforms. She encountered considerable opposition, but was able on most points to overcome it. The old system of a one

year's course for nurses was gradually extended to a three years' course with a four months' preparatory course and a carefully thought-out curriculum for the practical and theoretical instruction; night duty was systematically arranged, more staff was provided in the wards, the nurses' living conditions were improved, and salaries and pensions were raised. The long cherished hope that it might one day be possible to organize courses of instruction for patients who had to spend a long time in the hospital, technical subjects for adults and school subjects for children, was at last realized as the result of Sophie Mannerheim's energy and generosity. (She defrayed the expenses of the first courses from her own pocket.)

. . . . .

Sophie Mannerheim's sphere of activity continued to extend like the ever broadening, ever multiplying circles on the water where a stone has been cast. It was now not the Surgical Hospital alone, though it had always a special place in her heart, that took her time and energy. There was the students' home and school of nursing, the convalescent home and the holiday home for nurses, the so-called Red Hut, that she had instituted, and the nurses' journal, *Epione*, was published through her initiative. She had occasionally taken part in congresses in foreign countries and, as an indirect result, the nurses' association became a member of the International Council of Nurses and sent representatives to conferences in different parts of Europe and even to America. Sophie Mannerheim continued to take part in these meetings and her name became more and more known, and the force of her personality was increasingly felt. Out in the world she began to be regarded as a force to be reckoned with and an intelligence that could not be done without. Her advice was sought everywhere. Her correspondence covered the whole civilized world and of late years she travelled extensively in the interests of nursing, even visiting the Balkans and Greece. She was elected President of the International Council of Nurses for the three-year period 1922–1925, and thus became the head of all the nurses' associations in the world. At the end of this period the International Council of Nurses met in Helsingfors, and Sophie Mannerheim had achieved her end. Finland became widely known when the thousand nurses went back to their respective countries full of admiration for Finnish culture and the beauty of a Finnish summer.

Sophie Mannerheim was passionately loyal to her country. She worked first and foremost for the good of humanity and secondly for the glory of Finland. She loved her country far beyond all thought of politics, she loved the very earth, the very people, and wanted her country to distinguish itself in every possible way. She, too, shared in the general enthusiasm for the war of freedom, she more than any other, for it was her own brother who led the White Army to victory, and the 16th of May, 1918, was certainly the happiest day of her life. During the post-war years, when there was neither food nor money, she worked as one inspired.

. . . . .

Sophie Mannerheim had the good fortune to see the fruits of much of her work during her lifetime. Honors were showered upon her. She received the Florence Nightingale Medal and also Finland's White Rose. She was President of the International Council of Nurses and Chairman of the Advisory Committee on Nursing of the League of Red Cross Societies. She was further honored by a request to set up a school of nursing in Paris entirely upon her own lines. Unlimited funds had been promised from America for this great undertaking which aroused her deepest interest but which, unfortunately, was never carried out because she became seriously ill and the whole plan had been based exclusively upon confidence in her ability and personality. It was a great disappointment to her to be obliged to refuse and she often thought regretfully, during her last illness, of what might have been done. Here in Finland she was made an honorary member of General Mannerheim's League of Child Welfare and a member of the State Child Welfare Committee.

No other woman in our country has won such general esteem and such high honors. But Sophie Mannerheim thought little of her own worth. She knew that much still remained to be done, that the struggle for her ideals was becoming more difficult year by year, on account of the changing conditions in the country after the war. But she was undaunted, she had more than enough moral courage and was ever ready to fling herself into the breach in case of need. She knew no fear.

She had many opportunities in her life of showing that she had this unbounded moral courage, the hallmark of breeding, and she also showed great physical courage during the two long and severe illnesses, which one after the other finally wore away her strength so that on January 9, 1928, she bade farewell to the life she had so much loved, life in the service of humanity.

Abstracts

Scarlet Fever: M. V. Veldee, M.D. The Present Status of Streptococcus Biologic Products in the Prevention and Treatment of Scarlet Fever. (*Public Health Reports by the United States Health Service*, August 8, 1930.)

The use of scarlet-fever streptococcus toxin and scarlet-fever streptococcus antitoxin for the prevention and treatment of scarlet fever was discussed before this conference in 1926. (Conference of State and Territorial Health Officers.) It was the opinion of the members that:

1. The intradermal reaction to scarlet-fever streptococcus toxin is a fairly dependable measure of the susceptibility of the individual tested.

2. The majority of the individuals giving a positive reaction can be effectively immunized by the proper use of scarlet-fever streptococcus toxin.

3. The use of scarlet-fever streptococcus antitoxin, either for passive immunization or for the treatment of the individual ill with scarlet fever, is not yet founded on sufficient clinical data to permit a mature opinion as to the efficacy of this form of treatment.

There seems to be little reason to alter the opinions just mentioned. The accumulated data, however, have served to crystallize our opinions and to clarify the atmosphere somewhat. . . . The findings indicate that hemolytic streptococci may be isolated from the throats of persons ill with scarlet fever, from persons who have recently recovered from an attack of scarlet fever, from healthy persons who have had contact with those known to harbor the organism, and often from the throats of persons whose history gives no indication of association with scarlet fever. . . .

The subcutaneous injection into Dick-positive individuals of sufficient quantities of scarlet-fever streptococcus toxin will change the skin reaction from positive to negative in a very large percentage of those injected. What influence such treatment has on the prevalence of scarlet fever in a large community cannot be stated at the present time. . . .

Kiefer and others have reported on the disappearance of scarlet fever from institutions in which there has been active immunization of those inmates showing a positive Dick test. While the presumption is strong that such immunization did eliminate institutional scarlet fever, yet the small number of individuals usually involved and the low prevalence in the community at large leave some possibility for the play of chance. . . .

Agreement is fairly general that scarlet-fever streptococcus toxin has found a definite field of usefulness in the active immunization of persons susceptible to scarlet fever. However, agreement has not been reached as to the number of injections of the total dose of toxin required for the production of immunity. Enough must be given to produce a high percentage of immunes, but at the same time it must not be forgotten that reactions do occur. The reactions are not serious from the standpoint of endangering life, and therefore may be overlooked in institutional work, but they do become of great importance in private practice.

The time has not yet arrived for the proper evaluation of scarlet-fever streptococcus antitoxin in the treatment of scarlet fever. . . . Various clinicians, who are from experience qualified to form an opinion, have stated to the writer that it is their belief that a really potent scarlet-fever streptococcus antiserum is of benefit in the treatment of selected cases. We still are in need of a very closely controlled clinical demonstration of the therapeutic value of such antiserum. . . . There are certain shortcomings which need correction before the health officer can afford to push their use very energetically. I refer particularly to the practice of using five injections of toxin, low in potency, relatively high in protein content, which causes annoying reactions in a fairly large per cent of those treated. . . . In order to attain general acceptance and usage, we must have a product which will require fewer doses and cause less reaction.

The Catholic Hospital Association

REV. ALPHONSE M. SCHWITALLA, S.J.

THE Fifteenth Annual Convention of the Catholic Hospital Association of the United States and Canada met at the Catholic University of America, September 2–5, 1930.

This was, undoubtedly, one of the most successful conventions ever held by the Association. About four hundred hospitals were represented. The papers were of more than ordinary merit. The participation of authorities from the hospital, the medical, the nursing, the social service, and other fields was noteworthy. The importance of the newer developments of nursing was touched upon in some form or another in every one of the general meetings and in several of the sectional meetings.

The President, in his opening address, called attention to nursing problems; first of all, in their relation to Religious Orders of Sisters who conduct the Catholic hospitals, and, secondly, in relation to the schools of nursing conducted by the hospitals. Concerning the first point the President said, "The continued success of our hospitals cannot be assured unless we have a steady supply of religious vocations and unless novices pour in in increasing numbers into the novitiates of our nursing Sisterhoods." He pleaded for a careful study of the problem of an adequate supply of applicants for our religious orders. Concerning the second phase of the nursing problem in the Catholic institutions, the President said:

> Our schools of nursing must concern themselves not only with the education of the lay nurse but with what is even more important to stress at the present moment, the education of the Sister-nurse. Not one of you listening to me here but sees the differences both administratively, educationally, and spiritually between the development of the lay nurse and the Sister-nurse. . . . Our schools of nursing have ceased to be merely training schools, they are becoming more and more strictly comparable to our colleges for women. And, therefore, in addition to the old problems faced by our directresses of nurses and other officials, we have the new problems centering in women's education to understand and to solve.

The President recommended a study of the nursing schools and Catholic institutions.

> I would not counsel that we undertake a study which will overlap the study of the Grading Committee. I would rather use the findings of the Grading Committee as basic to a further study of our Catholic institutions with special reference first to the collegiate ideal and secondly to the development of these schools for the Sister student nurse.

These remarks culminated in two resolutions which were adopted in the final session of the Association upon recommendation of the Executive Board. The first of these resolutions called for the establishment immediately of a committee to take active steps for the promotion of the study of the adequacy of the number of religious vocations to the nursing Sisterhoods. The second of these resolutions reads as follows:

> BE IT FURTHER RESOLVED, that this Association undertake, as soon as the project can be adequately formulated, a study of nursing education in our Catholic institutions with special reference to the ideal of an administrative separation of our schools of nursing from the hospitals to which those schools are attached; that this Association express its satisfaction over the purposes and aims of the Grading Committee, and express at the same time its hopes concerning the great benefit to the profession of nursing which is expected to result from the work of this committee.

In the sectional meeting on Tuesday afternoon, which dealt with the

problem of "The Education of Hospital Directors," the problems of the nurse's life within the hospital were constantly kept in mind. On that same afternoon a special meeting was devoted to the question of Nursing Education. The meeting was presided over by the Reverend Patrick J. Mahan, S.J., Regent of Loyola University School of Medicine. Sister M. Felician of St. Anthony's Hospital, St. Louis, presented a survey paper on "The Catholic Hospital in the History of Nursing Education." With the freshness of an enthusiast she selected features from the earliest days of Christian life to the present to illustrate the point that the whole history of nursing education is inspired by religious devotion and sacrifice. Sister M. Aloysius, the Dean of St. Theresa's College, Winona, Minnesota, presented a most helpful paper full of suggestions which she called "New Lamps." She pleaded for the establishment of a central medical school with a central school of nursing "as a woman's project."

This Catholic Central College for Nurses should be entirely independent of any hospital in its center while maintaining affiliations with all of them. . . . The existence of even one such institution in the country would add immeasurably to the academic and professional prestige of our Catholic hospitals and nursing schools and it would signalize in a notable way the school idea in nursing as independent and distinct from the hospital idea, while in no way minimizing the importance of the hospital but in a very distinct and necessary way extending the idea of the school.

Dr. E. Lee Shrader, Director of the Student Health Service at St. Louis University and Instructor in Case Study at the same university, read a paper on "Teaching Methods in Case Study." This paper well deserves very careful perusal for it lays down in a most practical and yet definite way the aims and purposes of case studies. Dr. Shrader pleaded for greater freedom in the presentation of case studies, a freedom for the individual nurse "to tell her story in her own way." While the author conceded that in many cases a predetermined form had best be used in the beginning of the nurse's approach to this subject, he also recognized the fact that in the course of time the individual initiative of the nurse should be allotted the fullest play.

There is a certain amount of the detective in all of us. . . . In all of us there is a certain challenge, a certain thrill in attempting to understand the unknown and explain it, to know the reason why and to apply the remedy. This is in a sense the true scientific spirit. The goal of scientific nursing is the intelligent application of the remedy in detail to the case of the sick. If the nurse understands this scientific spirit which is one of the great moving forces in medicine, she can carry out much more intelligently her part of this scientific attitude as it is applied in the care of the sick. The case study method of teaching is the practical application of this spirit.

Sister M. Barbea, Superintendent, St. Elizabeth's Hospital, Lafayette, Indiana, next touched upon one of the most difficult of the problems discussed at this convention, "The Special Problems of the Sister Student Nurse." Sister Barbea called attention to the fact that the outstanding problems which, in her opinion, confronted the Sister student body today pertain, first of all, to the moral, social, and personal conflicts which may be developed as a result of the intermingling of the lay and Sister groups in the same class; secondly, the difficulties arising from the wide differences in the educational backgrounds of these two groups. All of these points were repeatedly expressed, not only in this but in other papers. The Reverend James F. Barrett, author of "Psychology for Nurses," read a paper on

"Teaching of Psychology for the Student Nurse." Father Barrett is lecturer in Psychology in St. Francis Hospital, Hartford, Connecticut. He pointed out that, from the viewpoint of the training school superintendent, the practical consequences of the study of psychology are numerous. An insight into the data of consciousness, into the nature and operations of the mind, and into the mental abnormalities conditioning behavior are a practical preparation for every nurse.

The general meeting on Wednesday morning was given over to the study of "The Religious Life of the Hospital." In the sectional meeting of Wednesday afternoon, several nursing problems were again touched upon, professedly or casually. The Reverend Karl J. Alter's paper on "Relation of Hospital Social Service to Other Fields of Social Service," Irene Morris' on "The Medical Social Service Curriculum," Ida Cannon's on "Social Service and the Medical Specialties," as well as the other papers, all contained suggestive and valuable material to nurses. The other two sectional meetings devoted themselves to the "Hospital Records and the Medical Library" and to "Staff Organization and Procedure."

During the general meeting on Thursday morning, in which the "Life of the Hospital within the Community" was discussed, Sister M. Claudia, the Registrar of Nazareth College, Nazareth, Michigan, in her paper on "The Relation of the Teaching Sister and the Nursing Sister" took occasion again to express the importance of bringing home to the nursing Sister her educational duties. Sister M. Claudia, in her forward-looking paper, discussed the situation which she hopes may be developed in the future. "Together they, the nursing Sister and the teaching Sister, study psychology, ethics, and sociology, pursue courses in English and in foreign languages, perform experiments in the biological and chemical laboratories, and in class and outside of it they may discuss freely both their common and their divergent interests."

The concluding general meeting on Friday morning was devoted entirely to schools of nursing. Father Mahan, of Loyola University, presented the first paper on the "Relation of the School of Nursing to the Hospital."

> The most important modification of this relation which I would suggest is that the school be granted a certain degree of independence and autonomy both in authority and in finances. . . . The second modification, regarding the service of the student nurse to the patients—the directress or dean of the school must be a college graduate. She must have a good pedagogical training and she must have a fair acquaintance with what is being done in some of the best schools, either by experience or by observation. She must have two full-time instructors with qualifications equal to her own.

Sister M. Brendan, of St. John's Hospital, St. Louis, then read a summary of the complex relationship existing between St. Louis University, on the one hand, and three of the nursing schools in St. Louis, on the other hand. Sister Brendan said:

> At present, as a result of this relationship, the students take their academic work more seriously, they have a truer sense of their own importance, they need less correction in the halls as they seem to carry over methods learned in the science laboratories to their methods in nursing technic. The interest of the graduate nurse is stimulated by the progressive educational policies adopted and she is attracted by the courses offered to graduates.

The difficult problem of "School Administration for the Education Director," was discussed by Sister Helen Jarrell, of St. Bernard's Hospital, Chicago. She concluded with a note of optimism.

Sister M. Giles, Superintendent of Nurses of St. Joseph's Hospital, Kansas City, Missouri, contributed to the

vexing question of "Central Schools of Nursing."

I have tried to set before you the present day veerings toward education in the central nursing schools. My choice would be that of the college-school type of centralized instruction where, after evaluation of their personality and mentality, we accept our own students, house them, use our own hospital for a practice field, and send them to the college for their scientific instruction.

Susan C. Francis next presented briefly "The Results of the Work of the Grading Committee." Her remarks all led up to an ample justification of the resolution adopted last January by the boards of directors of the various associations interested in the Grading Committee's work; "that the nursing profession assume the obligations, moral and financial, for assuring the continuation of the work of the Grading Committee." The last speaker on nursing problems in that morning's session was Mary T. Dowling, who summarized the work of the International Catholic Federation of Nurses. She showed what had been accomplished and what the Federation still expects to do. The question of the relation between the Federation and the Catholic Hospital Association, of which the Federation is an offspring, has long been under discussion. It may be hoped, however, that this problem is at last solved, for both the Federation and the Catholic Hospital Association have committed themselves to certain fundamental principles. These principles are embodied in the resolution recommended by the Executive Board of the Catholic Hospital Association and approved by the Association. It reads as follows:

BE IT FURTHER RESOLVED, that the Association pledge its active coöperation with . . . the International Catholic Federation of Nurses, in accordance with the principles of coöperation drafted by the Executive Board and by the joint committees of this Association and of the Federation . . .

SPECIAL RESOLUTION,

Concerning the suggested relationship between the Catholic Hospital Association and the International Catholic Federation of Nurses:

1. This relationship should be one of mutual understanding and active coöperation through the study of common and overlapping problems, through the support of the official organs of the two associations, through the creation of a joint committee and through the joint furtherance of the interest of student and graduate nurses in our Catholic Schools of Nursing.

2. The predominating sphere of influence of the Catholic Hospital Association will be the student nurse in our schools of nursing, which schools should remain the responsibility of the Sisters who have organized and developed them and who have developed in them the highest educational, ethical and spiritual standards.

3. The predominating sphere of influence of the International Catholic Federation of Nurses should be the graduate nurse, with special reference to her spiritual and social development and to her educational development in so far as this can be promoted independently of the schools of nursing.

From this summary it may be seen that practically one fifth of the papers presented at the Catholic Hospital Association Convention have had some bearing upon nursing problems. That all of this is most gratifying to the Sisters became evident through the strong and frequent remarks of approval which the program committee received from all the participants in the convention. It is abundantly clear that nursing problems will continue to form one of the chief centers of interest of the Catholic Hospital Association.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

Proceedings

The Proceedings of the Twenty-seventh Convention of the American Nurses' Association have been published and now are available at Headquarters for the price of 75 cents. So far as we know, this is the earliest date of publication for the Proceedings and we are very glad indeed to have them ready for the state meetings. This publication, of course, is extremely valuable as historical data for any schools of nursing, state, district, or alumnae associations or similar groups. It is most helpful to speakers and students. But this year the Proceedings seem to be of particular value to the individual nurse because the problems discussed at the Milwaukee Convention were of such a personalized nature. Unemployment, its causes and possible remedies, was vigorously discussed. Nurses' insurance and the question of national relief were defined and debated. Opportunities in mental hygiene and psychiatric nursing, in the field of office nursing, in group nursing, hourly nursing, and anesthesia were pointed out while the relation of the work of the individual nurse to the community's demand for nursing care was emphasized in more than one session.

Articles of Incorporation and By-Laws American Nurses' Association

The Articles of Incorporation and By-Laws of the American Nurses' Association have been reprinted as amended at the Biennial Meeting in June, 1930, and are ready for distribution. As has heretofore been the custom, a supply has been offered to the state associations sufficient to permit distribution as indicated below:

One copy for President's Portfolio.
One copy for each of the following *state association officers:* President, Secretary, Treasurer.
One copy for each of the following *district association officers:* President, Secretary.
One copy for each alumnae association president.

Additional copies may be had at 10 cents each or, if ordered in lots of 100 or more, at 8 cents, by writing to Headquarters.

The A. N. A. Answers Questions

Sometimes Headquarters feels as if it were buried in a mass of correspondence. Sometimes it seems impossible to keep pace in answering letters, with more letters constantly appearing to be answered. The Headquarters staff, need it be said, is ever so happy to have it this way. For the more questions are asked of Headquarters, the more surely the American Nurses' Association is going to be aware of the problems and seek the answers for the nurses in the states. It seems to Headquarters, moreover, that some of these questions may be perplexing more nurses than that individual who wrote her problem to her national office.

So beginning herewith, we are publishing each month in this column some of the queries that come to us and some of the answers given. Here are a few of the definitions and paragraphs of information:

What is an Official Registry? "At the present time, the only requirements for an official registry are (1) that the registry be conducted under the auspices of an association affiliated with the American Nurses' Association; (2) that the registrar be on a salary. Therefore, if the registrar of your official registry is being paid a salary, and if the registry is conducted by an association such as that described, we suggest that the secretary of your district association write to the secretary of your state association, and request that notice that the

registry meets the above-noted requirements be sent to the *American Journal of Nursing*. The registry will then be listed in that publication as an Official Registry."

I am interested in nursing in China. How can I obtain information on this subject? "Cora Simpson, General Secretary, Nurses' Association of China, Nanking, China, will be able to give you detailed information concerning nursing conditions in that country. We believe that the Women's Union Missionary Society of America, Astor Place, New York, which we understand places missionaries in Asia, and the Federation of Woman's Boards of Foreign Missions of North America, 25 Madison Avenue, New York, will be able to advise you as to the possibility of your going to China under religious auspices. We also suggest your writing to Mary Beard, care of Rockefeller Foundation, 61 Broadway, New York, requesting information and asking for an application blank. The Foundation has informed us that nurses desiring work in foreign countries may register there, although they do not promise positions. A few training school positions for well qualified nurses (high school graduation, at least, a prerequisite) are immediately available in Peping. The Secretary of the International Council of Nurses, Christiane Reimann, in Geneva, Switzerland, has information concerning work in foreign countries."

What is the present form for Alumnae Constitution and By-Laws recommended by the American Nurses' Association? "We have available at Headquarters a complete set of forms as follows:

"Form of Application for Membership of Alumnae Associations.

"Suggested Procedure to Form an Alumnae Association. Model Form for Alumnae Constitution and By-Laws.

"Form of Application for Membership of District Associations.

"Proposed Constitution and By-Laws for District Associations of a State."

Nurses' Relief Fund

REPORT FOR MONTH ENDING AUG. 31, 1930

Receipts

Interest on investments	$75.00
Interest on bank balances	10.32

Contributions

Arkansas: District 6-A	20.00
California: State Assn.	31.55
District of Columbia: Individual member	1.00
Florida: District 8	28.00
Georgia: State Assn., $6; Davis Fischer Alumnae Assn., Atlanta, $10	16.00
Missouri: University Hospital Alumnae Assn.	$11.00
New Jersey: District 1, Essex County Homeopathic Hospital Alumnae Assn., $50; Newark Memorial Hospital Alumnae Assn., $10; individuals, $26; District 2, Passaic General Hospital Alumnae Assn., $20; Englewood Hospital Alumnae Assn., $10	116.00
Tennessee: District 4 (Chattanooga)	156.00
Texas: District 6	2.00
Wisconsin: District 2, Janesville, $26; District 4 and 5, Mt. Sinai Alumnae Assn., $22; Milwaukee County Hospital Alumnae Assn., $25; District 6, Neenah, $131; District 10 (Sacred Heart, Luther, Lady Smith alumnae assns., individuals), $105; District 12, Manitowoc, $50	359.00
Total contributions	$740.55
Total receipts	$825.87

Disbursements

Paid to 186 applicants	$2,802.00
Custodian fee for six months	65.00
Check returned by bank	1.00
Total disbursements	$2,868.00
Excess of disbursements over income for month ending August 1, 1930	$2,042.13

Through the settlement of the estate of Adelaide E. White, late of Wellsboro, Pa., the principal of the Fund has been increased by a gift of $2,946.71 in cash (to be invested by the Finance Committee) and three $1,000 bonds.

All contributions to the Nurses' Relief Fund should be made payable to the Nurses' Relief Fund and sent either to the person who collects your dues or to the local Relief Fund Chairman. The method of collection of contributions varies in the different states. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman, or the Director of the American Nurses' Association, Headquarters, 370 Seventh Avenue, New York City.

The Isabel Hampton Robb Memorial Fund

REPORT TO SEPTEMBER 11, 1930

Previously acknowledged	$35,149.12

Contributions

Iowa: District 2, $10; District 6, $10; St. Joseph's Mercy Hospital Alumnae Assn., Sioux City, $5	25.00
Wyoming: State Assn.	10.00
Total	$35,184.12

MARY M. RIDDLE, *Treasurer.*

The McIsaac Loan Fund

REPORT TO SEPTEMBER 11, 1930

August 4, balance	$981.32
Bank interest	.33
Contributions	
Iowa: District 2, $10; District 6, $10; St. Joseph's Mercy Hospital Alumnae Assn., Sioux City, $5	25.00
Wyoming: State Assn.	10.00
Total	$1,116.65
Disbursements	
Four loans of $200 each	$800.00
One loan of $100	100.00
	$900.00
September 11, Balance	$116.65

MARY M. RIDDLE, *Treasurer.*

Scholarships are awarded once a year in the spring. Loans are made to approved candidates when the state of the treasury warrants. Contributions are greatly needed, especially to the McIsaac Loan Fund, as there is a list of waiting applicants.

Contributions for either fund may be addressed to the Treasurer, Mary M. Riddle, Care American Journal of Nursing, 370 Seventh Avenue, New York. For application blanks, address the Secretary, Katharine DeWitt, at the same address.

Army Nurse Corps

During the month of August, 1930, orders were issued for the transfer of members of the Army Nurse Corps to the stations indicated: To William Beaumont General Hospital, El Paso, Texas, 2nd Lieut. Ola W. Grant; to Fitzsimons General Hospital, Denver, Colo., 2nd Lieut. Jane Coddington; to Letterman General Hospital, San Francisco, Calif., 1st Lieut. Margaret Knierim, Chief Nurse, 2nd Lieuts. Olive C. Blazey, Catherine I. Duffey, Katharine L. LaRose; to Walter Reed General Hospital, Washington, D. C., 1st Lieut. Elida Raffensperger, Chief Nurse, 2nd Lieuts. Madolin E. Milheim, Mary Miller, Elsie Schwaeble, Gertrude A. MacLean, Ruby Poss, and Sara A. Clark; to the Hawaiian Department, 2nd Lieuts. Louise Fennelle, Ruth J. Riggs, and Ellen Whelton; to the Philippine Department, 1st Lieut. Clara E. Ellwanger, Chief Nurse, 2nd Lieuts. Ida May Shlevin and Jessie C. Thompson.

Nine were admitted to the Corps, as Second Lieutenants: Sallye O'Bannon, Jeanne E. McKusick, Queenie Kennedy, Frieda A. Montgomery, Ava Lee Morrison, Muriel E. Devereaux, Lillian I. Pease, Vera L. Kakac, Alice E. Moore, Maxine M. McCaffery, Esther M. Hougan, Madeline M. Bahl, Nancie Allen, Katherine C. Kocyan, and Roma Kilgore.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

During the month of August, eight nurses have been appointed and assigned to duty.

The following transfers were made: to Chelsea Mass., Mary P. Leader, Chief Nurse; to Great Lakes, Ill., Ruth Abrams, Lydia B. Ranson, Anna W. Gray; to League Island, Pa., Mary L. Benner; to Mare Island, Calif., Orla E. Maley; to Norfolk, Va., Helen L. McKenzie, Chief Nurse, Francis D. Johnson; to Dispensary, Navy Yard, New York, Isabella F. Erskine, Chief Nurse; to Dispensary, Pearl Harbor, T. H., Adah M. Pendleton, Chief Nurse: to Parris Island, S. C., Mollie Detweiler, Chief Nurse, Florence V. Cole; to Pensacola, Fla., Mathilda E. Hume, Mary Rose Love; to Portsmouth, N. H., Marian Simmons; to San Diego, Calif., Mary B. Roberts, Kathleen F. Smith; to Washington, D. C., Edith A. Ahlstrom.

The following nurses have been separated from the Service: Mary Anna Allen, Edith Carter, Elizabeth M. Coombs, Sarah F. Herrity, Antoinette M. Kozel, Gertrude Lett, Genevieve Frances Mamel, Lucy Roncelli, Elda Spelta, Martha H. Velo, Anna L. Wheeler.

J. BEATRICE BOWMAN.

U. S. Public Health Service

The following transfers, reinstatements, and new assignments have been made in the U. S. Public Health Service during the month of August, 1930:

Transfers: to U. S. Penitentiary, Atlanta, Ga., Clara Schmidt, Chief Nurse, Jennie Allen; to U. S. Penitentiary, Alderson, W. Va., Grace Craney, Chief Nurse, Erma G. Morrison, Gladys Dickinson, Martha Jane Lacy, Vivian Farrell, Eleanor Dillon; to U. S. Penitentiary, Leavensworth, Kans., Wilhelmina Henley, Chief Nurse, Claire Furlong, Jennie MacDonald.

Reinstatements: Mildred Pratt, Mary Hazlip, Sarah Blakeley, Hattie Haigwood, Helen Churchill, Chief Nurse, Marie Sheridan, Mary Dill, Nell Locke Tunstall, Imogene Sullivan, Elva Wisenant Denton.

New Assignments: Twenty-four.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

United States Veterans Bureau

REPORT OF NURSING SERVICE AUGUST, 1930

During the month of August, following a tour of inspection of the territory to be served by the proposed new 400 bed neuropsychiatric hospital in western New York, it was recommended by Gen. Frank T. Hines (Administrator of Veterans' Affairs), Chairman of the Federal Hospitalization Board, charged with selection of the site, that the Thompson estate at Canandaigua, N. Y., be approved as a nucleus. This consists of about 150 acres of land. However, it is believed that about 500 acres will be included in the entire site when it is finally assembled. Canandaigua, which is approximately 90 miles from Buffalo, has a population of about 7,500 and is located at an intermediate point between the largest cities in western New York state; the transportation facilities from it to other parts of the area which the new hospital will be required to serve are excellent. In general, it is felt that this site overlooking Canandaigua Lake is an ideal location. It is one of the outstanding show places of the country, and was developed at a cost of $2,000,000 by the daughter of former Governor Clark. It is named Sonnenberg, "Sunny Mountain." On the estate there is a magnificent mansion which it is expected may be used as an administration building. The countless gardens of Sonnenberg lure people from all parts of the country and twice a year students of horticulture, agriculture, botany and biology at Cornell University visit the estate. It is an ideal setting for the type of hospital which the government proposes to erect upon it.

Announcement is made by Mary A. Hickey, Superintendent of Nurses of this Bureau, that instruction in the third course in neuropsychiatric nursing will begin at the U. S. Veterans' Hospital, Bronx, N. Y., October 1 and continue to January 1, 1931. This course is given to selected nursing personnel of demonstrated ability. Its importance cannot be overemphasized in view of the constantly increasing load of neuropsychiatric cases.

It is expected that the installation of sound motion pictures in all hospitals maintained by the Veterans' Bureau will in the future be a potent factor in improving the well-being of sick and disabled veterans. Silent movies have been a regular feature of recreation at the hospitals for a number of years, but sound equipment has only recently been adapted to the needs of the Bureau. This equipment covers a special type of nontheatrical equipment suitable for hospitals. It is complete in every detail and is augmented by attachments which make possible the playing of phonograph records through the amplifiers, so that music for dancing or for religious services may be available to the patients at any time. Installations are under way in a number of veterans' hospitals, and it is anticipated that all those having recreation halls or other suitable facilities will be equipped by Christmas. Eventually this feature of entertainment may be installed in all the hospitals now under the veterans' administration, which includes the eleven National Homes for Disabled Volunteer Soldiers. Another branch of these Homes was recently authorized by Congress to be built in a southeastern state.

The new veterans' hospital at Coatesville, Pa., it is expected will be ready for the reception of patients on or about October 15.

During the month of August, the following-named nurses were reinstated in the nursing service: Lydia Richter, Bess Jenkins, Matilda Papenhausen.

Twenty-one new assignments were made. The following were separated from the service: Alberta Adams, Teresa Benham, Sue Bigler, Ethel A. Blair, Ellen Chamberlain, Agatha D. Cook, Rose B. Doherty, Catherine Donahue, Mary Fennelly, Norma C. Flugum, Edna Garrett, Mary E. Grill, Lillian Johnston, Elise Knutsen, Lottie R. Ladiner, Margaret Low, Christene McKay, Lucy Moore, Anna O'Donnell, Minnie Robbins, Adeline E. Roesler, Flora E. Smith, Dolly A. Smothers, Cora Sorrels, Ida Stapleton, Ruth Trainor, Virgie M. Walker, Leanna Wheatley, Euphrosyne Zilla.

Transfers: To Dwight, Ill., Laura A. Beecroft; to Tucson, Ariz., Emily A. Jummell, Rose Henchliffe, Ida Postell; to Alexandria, La., Ida Stoskopf; to Sunmount, N. Y., Rose Bannigan, Juanita Jones, Mary Murphy; to Ft. Snelling, Minn., Amy Ryan, Hilda Brantner; to Hines, Ill., Mary Devine; to Kansas City, Mo., Nellie Gifford, Clarrie Jewett; to San Fernando, Calif., Mary Graham, Eileen McCarthy; to Jefferson Barracks, Mo., Helen Hendricks.

MARY A. HICKEY,
Supt. Nurses, U. S. V. B.

U. S. Indian Service

During the month of August the following changes have taken place in the nursing personnel of the Indian Service:

Appointments: Seven.

Separations: Three.

Transfers: Fanny D. Rogers, from the Theodore Roosevelt School, Arizona, to the Pima Agency, Arizona.

ELINOR D. GREGG,
Supervisor of Nurses.

Institutes and Special Courses

Georgia: Immediately following the meeting of the Georgia State Nurses' Association, in Atlanta, there will be a two-day institute, October 30 and 31, under the auspices of the New York Maternity Center Association, coöperating with the 5th District Association of the Georgia State Nurses' Association. Enrollment is limited to sixty. There will be two-hour sessions, morning and afternoon. The fee will be $3. Nurses desiring to attend should communicate with Lillian Cumbee, care Wesley Memorial Hospital, Emory University, Ga.

Louisiana: The summer courses for nurses in Tulane University, New Orleans, were so successful that the University has already promised to assume a larger proportion of the expenses next year, thus justifying the courageous efforts of the State League of Nursing Education and the State Association which sponsored the courses. Gladys Sellew, Assistant Dean of Cook County School of Nursing, was director of the work and gave a course in Ward Administration and one on the Curriculum. Twenty-three nurses registered for the former and about fifteen for the latter course. They are reported as women of fine type who did good work.

Missouri: The MISSOURI STATE LEAGUE OF NURSING EDUCATION will hold an institute in Columbia, at the Tiger Hotel, October 9, 10, and 11, following the state meeting. Walter Horace Burr, University of Missouri, will lecture on "Applied Sociology" at 9 a.m. and 2 p.m., Thursday and Friday, and at 9 a.m., Saturday. Theophil William Henry Irion, University of Missouri, will lecture on "Adolescent Personality," "Learning," and "Supervision of Learning," at 10.30 a.m., in the morning. Margaret C. Hessler, University of Missouri, will lecture on "Nutrition" at 3.30 p.m., Thursday and Friday.

The lectures will be helpful to nurses in any field. The ticket for the course is $3; single sessions, 75 cents.

New York: DISTRICT 14 will hold its annual Institute in Brooklyn, November 19–21. On November 19, 8 p.m., at St. Mary's Hospital, the opening session will be held with an address, "The Philosophy of Learning," by Professor Licht of Columbia University.

Nov. 20, All-day session at Brooklyn State Hospital, subjects: "Mental Hygiene, Nursing in Mental Diseases, Syphilology." Evening session at Methodist Hospital, address, "The Spirit of Nursing," Father Garesché. Nov. 21, Demonstrations of nursing procedures at various hospitals in morning and afternoon. 2–4 p.m., At the Methodist Hospital, address, "The Art of Nursing," by Elizabeth C. Burgess of Teachers College. The evening session will include a dramatization of registry activities, of public health nursing, and an address on "The Value of the Annual Health Examination."

Ohio: DISTRICT 1 held an institute September 4 and 5, in Akron, with the following program: September 4, 1–3 p.m., visits to clinics—baby and tuberculosis. 3.15, Opening session—"Value of Staff Conferences," Flora Booth; Demonstration of a "Tuberculosis Home Visit on an Ambulatory Case," Akron Tuberculosis Clinic nurses; "Modern Methods of Teaching Health to School Children and How the Parents May Coöperate," E. V. Thiehoff, M.D. Evening session, Auditorium—"Tuberculosis" Slide Lecture, C. L. Hyde, M.D.; "Open Window Room," program in Akron Public Schools, Frieda Schweikart.

On Friday at 2.30 p.m., subjects presented were: "Newer Drugs," Sister Alma; "Spinal Anesthesia," Garnet Weisman; "Transportation of Patients," Margaret Norris; "Use of Tannic Acid in the Treatment of Burns," paper and demonstration, Edna Kannal; "Modern Methods of Infant Feeding," Mary Finlayson; "Nursing Care of Orthopedic Patients," Lulu Tuttle. At 6.45 three round tables were held: (1) Nina Wooton, Chairman, for Principals, Assistants and Instructors, "Training School Records"; (2) Mary E. Dickson, Chairman, for Night Supervisors and Assistants, "Use of Night Duty to Develop Student Self-Reliance and Responsibility"; (3) Sister Edith, Chairman, for Head Nurses, "Use of Case Study to Correlate Theory with Practice."

At the evening session, subjects were: "Carcinoma of the Breast, Stomach and Uterus," Carl R. Steinke, M.D.; "The Use of Radium and X-Ray in the Treatment of

STUDENTS AT FIRST SUMMER SCHOOL SESSION OF NURSES AT UNIVERSITY OF TEXAS

Carcinoma," Arthur H. Stall, M.D.; "The Nature of Malignancy," T. Harris Boughton, M.D.; Canti Film on Cancer, loaned by the American Society for the Control of Cancer.

Texas: The first courses in nursing education to be taught in the University of Texas were given in Austin in the summer session, July 22–August 29. Classes included courses in administration, teaching and supervision, making a six-point course. Three classes were held daily five days a week for the six weeks. The enrollment for this first session was thirty-six graduate nurses representing every district in Texas but one, with attendance also from Arkansas and Louisiana. In this number were included five Sisters, all occupying important posts in the state. Three students had studied in the Department of Nursing Education in Columbia University. The largest group was from the College of Nursing of the University of Texas, the oldest university school in America, which is at the John Sealy Hospital, located in Galveston. The students were received with enthusiasm and interest by the deans of the University. The Dean of Women supported the movement with enthusiasm. The Dean of the School of Education, in whose department the course was incorporated, was particularly interested and helpful. The spirit with which the registrar's office received the nurses, together with the choice of classrooms assigned, helped to make the session a success. Demonstration teaching was given at the Seaton Infirmary in Austin, with a group of preliminary student nurses as teaching material. All students enrolled for the courses were required to enroll also for one course in Psychology taught by professors of the University. Thorndike and Gates' *Elementary Principles of Education* was used as a text, and more copies of Kilpatrick's *Education for a Changing Civilization* were used for reference than any other single reference book. Mrs. Helen Lehman, President of the Texas State Nurses' Association, and A. Louise Deitrich, Secretary of the Association, visited and addressed the group. Public health nurses of Austin conducted several excursions to points of interest including the Capitol. Many have enrolled for the fall term in the University and will continue their studies in sciences allied to nursing. At the close of the term a recommendation was made by the student group to the Graduate Nurses' Association for the permanent establishment of the course with a yearly program to include additional sciences taught by graduate nurses. The instructors this year were Elsa Maurer, who had previously served as Dean of the School of Nursing, Baylor University Hospital, Dallas, and Jean Martin White, who had previously served as the first resident instructor in the College of Nursing, John Sealy Hospital, Galveston.

State Boards of Examiners

Alabama: The NURSES' BOARD OF EXAMINATION AND REGISTRATION will hold examination in Birmingham, October 14–15; in Montgomery, October 15–16; in Mobile, October 17–18. Applications may be secured from the Secretary, Linna H. Denny, 1320 North 25th Street, Birmingham. All credentials must be in the office before October 1. Kodak pictures will not be accepted.

District of Columbia: The NURSES' EXAMINING BOARD OF THE DISTRICT OF COLUMBIA will hold an examination for the registration of nurses, October 14 and 15, 1930, at the Franklin School, 13th and K Streets, N. W., Washington. All applications for examination must be in the office of the Executive Secretary, Bertha E. McAfee, 1746 K Street, N. W., by September 30.

Iowa: The IOWA BOARD OF NURSE EXAMINERS will hold an examination for registration of nurses at the State House, October 30–31.

Kentucky: An examination for graduate nurses will be conducted by the KENTUCKY BOARD OF NURSE EXAMINERS, in Louisville, on November 17 and 18, 1930. All necessary information and applications may be secured by writing to Flora E. Keen, Secretary, Thierman Apt. C-4, Louisville.

Louisiana: The next examination of the LOUISIANA NURSES' BOARD OF EXAMINERS will be held in New Orleans and in Shreveport, November 12 and 13, 1930. For further information, address Julie C. Tebo, Secretary, 1006 Pere Marquette Building, New Orleans.

Maryland: The MARYLAND STATE BOARD OF EXAMINERS OF NURSES will hold an examination for state registration, October 21, 22, 23, 1930. All applications must be filed not later than October 15 with the Secretary, Martha E. Friend, 1211 Cathedral Street, Baltimore.

New York: The President of the Board of Nurse Examiners, Sister M. Immaculata, has changed her address from Convent of Mercy, Rensselaer, to St. Peter's Hospital, Albany.

North Carolina: The NORTH CAROLINA BOARD OF NURSE EXAMINERS will hold examinations for graduate nurses, October 23, 24, and 25, at Raleigh. All applications must be filed with the Secretary, Mrs. Z. V. Conyers, Greensboro, before October 12, 1930.

Ohio: The NURSES' EXAMINING COMMITTEE OF OHIO will hold an examination for nurse registration in Columbus, December 12 and 13, 1930. All applications should be sent in well in advance of this date to the Chief Examiner, Room 203, 85 E. Gay Street, Columbus.

Oregon: The OREGON STATE BOARD FOR EXAMINATION AND REGISTRATION OF NURSES will conduct an examination for applicants desiring to register, in Portland October 30 and 31. No applications will be accepted after the 20th day of October. For further information write Grace L. Taylor, Secretary, 835 Belmont Street, Salem.

Rhode Island: The RHODE ISLAND BOARD OF EXAMINERS OF TRAINED NURSES will examine applicants for state registration on Thursday and Friday, November 13 and 14, beginning at 9 a.m., at the Rhode Island College of Education, Providence. Address the Acting Secretary, Lucy C. Ayers, Room 15, State House, Providence, for further information and application blanks.

State Associations

Alabama: The ALABAMA STATE NURSES' ASSOCIATION will hold its annual meeting at the Jefferson Davis Hotel, Montgomery, October 24–27.

Arkansas: The ARKANSAS STATE NURSES' ASSOCIATION will hold its annual meeting, October 27 and 28, at El Dorado, headquarters at Randolph Hotel. A very interesting program is being planned. District 7 invites all nurses to attend, not only to share in the business part, but also in all the entertainment that is being provided during the recreation time.

Connecticut: The CONNECTICUT STATE ASSOCIATION will hold its fall meeting on October 3, at New Britain.

District of Columbia: The GRADUATE NURSES' ASSOCIATION OF THE DISTRICT OF COLUMBIA has made a number of important changes in the past few months. In May, the office of executive secretary of the Association was created, and Bertha McAfee, the executive secretary of the Board of Nurse Examiners, was appointed to fill the position on a half-time basis. On August 1, the resignation of F. Katherine Vincent, for fifteen years the registrar of the Nurses' Official Registry, was accepted with appropriate expression of appreciation of devoted and valuable service, and Mary Weaver was appointed director. In the reorganization of the registry, which is now under way, in an effort to make the registry into a community service bureau in conformity to policies set forth by the American Nurses' Association registry studies, the director has been given three assistants who are to have eight-hour duty in rotation, so that the registry will have an active duty registrar for twenty-four hours a day. The final important change is the removal of the headquarters of the Graduate Nurses' Association, the registry, and the office of the Board of Nurse Examiners, to an apartment on the sixth floor of a professional building at 1746 K Street, Northwest, a few blocks away from the old club house at 1337 K Street. The new headquarters has space available for Board Committee meetings, and small receptions, but no residential rooms as had the club house. These changes mark a new epoch in the history of the Graduate Nurses' Association of the District of Columbia.

Georgia: The twenty-fourth annual convention of the GEORGIA STATE NURSES' ASSOCIATION will be held in Atlanta, October 27–29, the Ansley Hotel being headquarters. Nina D. Gage, Executive Secretary of the National League of Nursing Education, will be present to represent the National Headquarters of all three nursing organizations. Laura R. Logan, Dean of the Cook County Hospital School of Nursing, Chicago, and Shirley C. Titus, Dean of the School of Vanderbilt University, Nashville, Tenn., will also participate in the program of the convention. The State Association, the League of Nursing Education and the State Organization for Public Health Nursing have for a number of years been meeting jointly. The discussions of the League session this year will relate principally to problems in education. Those of the State Association will center around service, and round tables on school nursing, pre-school visiting and general public health nursing will feature the session of the S. O. P. H. N. A reception in honor of the visiting nurses, doctors, hospital administrators and others passing through Atlanta on their return from the convention of the American Hospital Association in New Orleans, will be held on the Ansley Hotel roof garden, Sunday afternoon, October 26.

The convention will open Monday morning, October 27, with Lucia Massee in the chair. Mrs. Eva S. Tupman, President of the Georgia League, will preside over the League session, and Emma Habenicht will conduct the annual meeting of the public health nurses. Eva Chalkley, Chairman, will preside over the meeting of the Private Duty Section. Dr. G. Y. Moore will be the principal speaker, discussing methods for effective medical and nursing service, especially as related to rural sections. Isabel Battle will discuss the relationship of the private duty nurse to the hospital, and Miss L. Saxon and Frances Blakely of Rome will also speak. Mrs. Sue Paillee will give a paper on "Making the Most of One's Self in Private Duty." Dr. R. C. Swint, Superintendent of the Georgia State Sanatorium, Milledgeville, will present a paper on "The Mental Disease Problem in Georgia." A session for discussion of problems connected with the organization of nursing service in homes will feature the convention, as will a session for office nurses, anesthetists and technicians, who for the first time will meet in a group under the auspices of the State Association. Hortense Marion and Sarah Dicey, Atlanta, will be among those contributing papers to this session. Mrs. S. B. Whittier of Chattahoochee will give a paper "Seeing Ourselves as Others See Us." There will be a Red Cross session, with Lillian Cumbee, Chairman of the State Committee, presiding, and reports of committees being given. Hattie Wilder, delegate to the National Convention, will give her report.

A two-day Maternity Institute will follow the State meeting. (See "Institutes.")

Illinois: The ILLINOIS STATE ASSOCIATION will hold its annual meeting on October 16–17, at Rockford, with headquarters at the Hotel Nelson. The program is outlined as follows: October 16, Business session and President's address. 12.30, Luncheon and business meeting of the State League. 1 p.m., Private Duty Section with these addresses: "Posture and Good Feet," Dr. Anna Weld, Rockford; "Our Progress in Contagious Diseases in the Last Fifty Years," Dr. Harold D. Palmer, Rockford; "How I Secured New Members for the Association in 1930," Geneva Martin. 4 p.m., Drive; 6 p.m., Dinner.

October 17, Public Health Section, with addresses: "Public Health Education," "Tuberculosis," Mrs. Violet H. Hodgson; "The Public Health Nurse in Home Economics," Fanine M. Brooks, University of Illinois.

12 noon, Luncheon, open to lay friends and board members of visiting nurse organizations.

Afternoon session in charge of the Illinois League of Nursing Education. "The Nurse in Education," William Arthur Maddox, Ph.D., President, Rockford College; "Predicting Success of Students in Schools of Nursing by Tests and Statistical Methods," Professor Jordan Cavan; "Student Health," Ada R. Crocker, St. Luke's Hospital, Chicago; "Annuities for Nurses," Carrie M. Hall, representing the Harmon Association for Advancement of Nursing. 4.30, Tea at Rockford College, V. N. A., and various hospitals. 7 p.m., Banquet, Crystal Room, Nelson Hotel, speaker: Reverend Charles Parker, "The Nurse as a Mental Hygienist."

October 18, 8 a.m., Red Cross breakfast with reports and an address by Louise Kinney. 9.30, Regular session, Janet M. Geister of National Headquarters speaker, address also on "The Medical Service in State Hospitals," Sidney D. Wilgus, M.D. 12.30, Luncheon of the Private Duty Section. Afternoon, Business session.

Iowa: The IOWA STATE NURSES' ASSOCIATION will hold its annual meeting in Burlington, October 8–10. The annual meeting of the Iowa League of Nursing Education will convene October 7, at Burlington, preceding the annual meeting of the Iowa State Association of Registered Nurses. Subjects of interest to every group will be presented. Round tables and open forums will provide ample opportunity for exchange of opinion on pertinent questions. Group luncheons, a banquet, teas, a reception, dance and card party will constitute the social side of the convention. A trip down the "Father of Waters" to Keokuk, with a view of the Keokuk dam, and tea at Graham Hospital, Keokuk, will close the convention.

Kansas: The KANSAS STATE ASSOCIATION will hold its annual meeting on October 9–11, at Manhattan.

Minnesota: The plans for the annual meeting call for a three days' convention for the three organizations to be held October 15–18 at the St. Paul Hotel, St. Paul.

Janet M. Geister, Director at Headquarters, Marie Jammè Stuhr, former President of the Minnesota State Registered Nurses' Association and now Executive Secretary of the Omaha District in Nebraska, and Dora M. Cornelisen, Field Representative of the *American Journal of Nursing*, will be speakers from outside the state. The first day will be given over to a meeting of the Advisory Council on Wednesday morning; Board of Directors' meeting at noon; opening business session,

M. S. R. N. A., in the afternoon and a meeting of anesthetists at the same time. Also, a session and tea for students. There will be a large open meeting at the Peoples' Church in the evening.

On Thursday morning there will be a joint session for everyone under the auspices of the S. O. P. H. N. The general subject of Mental Hygiene will be discussed from many angles by competent speakers. At noon the Red Cross luncheon will be held, and the committee in charge promise "a different kind of program." On Thursday afternoon, a joint program will be presented under supervision of the Minnesota League of Nursing Education which includes addresses by Eda Ferbert, Supervisor of Dietetics for the state institutions; Sister M. Domitilla and Janet Geister. The outstanding Silver Anniversary celebration will be the banquet and program Thursday evening. This will include a recognition service for the charter members and a uniform revue by two students from each of the nineteen schools in existence in 1905.

On Friday morning there will be sectional round tables for many groups including the S. O. P. H. N., the League and the Private Duty Section. At noon the S. O. P. H. N. will hold its annual business session luncheon, and at 2.30 the closing business session of the M. S. R. N. A. will be held. At the Private Duty meeting, a member of the University faculty will speak on some phase of psychology; Marie Jammè Stuhr will talk on "Private Duty Problems as Seen by the Registrar"; Julia Cassidy of St. Mary's Hospital, Rochester, will speak on "Group Nursing—a Reality." The October number of the *Minnesota Registered Nurse* contains historical articles on the state organizations. An interesting feature of the plans which promises much fun is an "Art gallery" of pictures of nurses and school affairs of twenty-five or more years ago.

Mississippi: The MISSISSIPPI STATE NURSES' ASSOCIATION will hold its nineteenth annual meeting at Natchez, on October 16 and 17, with headquarters at the Eola Hotel. Several nurses, outstanding in their profession, from outside Mississippi, will be present to add to the success of the meeting. Among those expected to be present are Julie Tebo, from Louisiana, who will read a paper before the Hospital Section, and Mrs. Alma Scott, from National Headquarters, who will add to the discussion of all sessions with a special emphasis on Organization. Natchez is one of the oldest and most interesting towns in Mississippi, and it is with a great deal of interest that the members look forward to the meeting there, as it was the birthplace of the State Association, the organization taking place there in 1911.

Missouri: The MISSOURI STATE NURSES' ASSOCIATION will hold its twenty-fourth annual meeting, and the STATE LEAGUE its twentieth, at the convention to be held October 6–8, in Columbia, with headquarters at the Hotel Tiger. The program includes speakers of national and state prominence; visits to the State University and the State Capitol, and the annual banquet. There will be round tables on Private Duty, Central Registries, Public Health, and one for state, district and alumnae secretaries. Luncheons will be arranged for Red Cross, private duty, public health and ex-service nurses, also for the Advisory Council, the League and the Student Council. An institute will follow the convention, on October 9–11. (See "Institutes.")

Nebraska: The NEBRASKA STATE NURSES' ASSOCIATION will hold its annual meeting in Omaha, October 13 and 14.

New York: The NEW YORK STATE NURSES' ASSOCIATION will hold its annual convention in Syracuse, in joint session with the State League of Nursing Education and the State Organization for Public Health Nursing, at the Hotels Syracuse and Onondaga, October 21–23. Three meetings are scheduled for Tuesday afternoon. The State League will meet for its first session. Following the business hour, Stella Goostray, Adviser, Joint Nursing Committee on Educational Policies, will give an address on "After the Grading Committee, What?" Following the business session of the Public Health Organization, Louise M. Tattershall, New York, will speak on "Standardization of Public Health Nursing Statistics." Mrs. Clifford will open the business meeting of private duty nurses, later turning it over to Cassie Rogers, New York State Chairman of Private Duty Nurses. After organizing as a section, the nurses will listen to Dr. Eliasoph, New York, on "Oxygen Therapy and Demonstration of a Portable Bed Tent." A symposium will follow on "The Professional and Economic Problems of Private Duty Nursing" and the "Relations of the Private Duty Nurse to the Public, the Medical Profession and the Superintendent." Marian Sheahan, President of the Public Health Organization, will preside at the joint session Tuesday evening. The speakers will include Mayor Rolland Marvin, Syracuse; Helen Wood, Rochester; Dr. Allan Craig, Chicago, on "Our Hospitals, Our Doctors, Our Nurses and Ourselves"; and Elinor

Gregg, Washington, on "The Indian Service and Other Government Nursing Services."

Wednesday morning, at the joint session, the speakers and their subjects are: Dr. Annie Louise MacLeod of Syracuse University, on "Education for Women"; Dr. Karl Leebrick, Syracuse University, on "The Need of a University Education for Professional Women," and Effie Taylor, Yale School of Nursing, on "What Constitutes Good Nursing Service." Wednesday afternoon, a joint meeting for private duty, League, registrars lay committee and board members will listen to "The Employment Situation in the Private Duty Field in New York State"; "The Official Registry's Service to the Public"; and Mary Gladwin, Akron, Ohio, will speak on "Group Nursing." At the same hour, public health nurses will hear Amelia Grant, New York, on "What Kind of Nursing Is Needed in Clinics?"; Louise Knapp, New York, on "The Plan for the Education of the Student Nurse in Vanderbilt Clinic"; and Dr. Thomas Parran, Jr., Albany, on "How Every Graduate Nurse Can Contribute to Public Health Work." Dr. Mabel Lytton, Syracuse University, will address the student nurses on "Leisure and Our Responsibility." The Advisory Council meets at 3.30 p.m.

Thursday morning, the speakers at the joint session are Dr. Emma Grant Meader, Troy, on "The Philosophy and Psychology of Supervision Applied to Nursing"; Gladys Sellew, Chicago, on "Supervision of the Graduate Nurses in a Hospital," and Mabelle S. Welsh, New York, on "Supervision of the Graduate Staff of Nurses in the Public Health Organization." Thursday afternoon, at the League meeting, Dr. Donald Clark, Columbia University, will speak on "Publicity Applied to Nursing Education Problems"; Virginia McCormick of the A. N. A. will talk on "The Nurse and the Public," followed by Mary Gladwin on "Morning Conferences with Student Nurses." At the same time, Pauline Alsberg of New York will address the Public Health Nurses on "Securing Employment for Mentally Handicapped," and Laura Gamble of the Cattaraugus County Health Department will talk on "Meeting Social Problems in the Rural Field." The session for the lay committee and board members includes addresses on the following subjects: "Why Read?" by Dorothy Deming of New York; "Why Be a Member of a Professional Organization?" by Mrs. Roessle McKinney, Albany; and "The Functions and Usefulness of a School of Nursing Committee" by Mrs. Linzee Blagden of the Board of Managers of Bellevue School of Nursing. The final business session of the State Association will open at 3.30 p.m.

Wednesday and Thursday, from 8 to 9 a.m., Sherman Kennedy, A.B., Professor of Forensics, Syracuse University, will hold classes in Parliamentary Law. Several special breakfasts and luncheons have been planned. Tuesday morning Alta Dines, State Chairman of the Relief Fund, will preside at a breakfast for district chairmen. A luncheon for enrolled Red Cross nurses will be open to *all* nurses. Wednesday, Mary Dowling of New York will preside at the breakfast for industrial nurses, and Grace Allison, Troy, Chairman State Legislative Committee, will meet the district legislative chairmen at breakfast. At the same time the directors of registries will meet with Emma Collins, Brooklyn. The following luncheons have been arranged for Wednesday: Mrs. J. Morton Halstead of Brooklyn will preside at the luncheon for members of hospital boards, visiting nurse association boards, nursing school committees and Red Cross committees. Mary Thornton Davis will preside at the public health luncheon, and Clara Quereau, Secretary of the State Board of Nurse Examiners, will meet directors of schools of nursing. The banquet is planned for 7 p.m. On Thursday, Miss Hicks will meet the district presidents and secretaries for breakfast. Three luncheons have been arranged for: School nurses—Anna Neukom of Albany presiding; student nurse delegates—Genevieve Clifford presiding, and the alumnae presidents and secretaries with Emily Hicks presiding.

North Dakota: The annual meeting of the NORTH DAKOTA STATE ASSOCIATION will be held in Fargo, October 14–17.

Oklahoma: The OKLAHOMA STATE NURSES' ASSOCIATION will hold its annual meeting in McAlester, October 29–31. An unusually good program has been arranged with several novel features in the way of social affairs. Those on the program from out of the state are: Janet Geister, Director of Headquarters, A. N. A., New York City; Louise Dietrich, Educational Director for the State Nurses' Association of Texas; Alma C. Haupt, Associate Director, National Organization for Public Health Nursing, New York; Louise Kinney, Assistant to the Director of Home Hygiene and Care of the Sick Service, St. Louis. A number of noted speakers from the state are also to give some very interesting talks: Dr. Paul Vogt, Dean of Extension Division of the Oklahoma State University; Dr. Allen Ruggles, Professor of Educational Psychology, also from the State University;

Dr. J. F. Page, Associate Professor of Economics, A. and M. College, Stillwater, Minn.

Pennsylvania: The twentieth annual convention of the GRADUATE NURSES' ASSOCIATION OF THE STATE OF PENNSYLVANIA, in joint session with the PENNSYLVANIA LEAGUE OF NURSING EDUCATION and the PENNSYLVANIA ORGANIZATION FOR PUBLIC HEALTH NURSING, will be held in Allentown, October 27–31, with headquarters at the Americus Hotel. On Sunday evening, the 26th, a service will be held in memory of S. Lillian Clayton.

October 27, 8 a.m., Round table on Ethics, conducted by Mary M. Roberts. The morning and afternoon session of the State Association will be devoted to business and reports. 8 p.m., Formal opening session with addresses by the three presidents of the state organizations, and one on "Peace" by Dr. Henry A. Atkinson.

October 28, 8 a. m., Round table on Ethics, followed by a business session of the State Association. Noon, a luncheon with addresses by J. Beatrice Bowman, Navy Nurse Corps, and Mrs. Mary A. Hickey, U. S. Veterans' Bureau. 2 p.m., Red Cross session and round table. 3.20 p.m., Drive and tea. 8 p.m., "Glandular Therapy in Relation to Human Activity," Dr. Francis J. Dever; "Nurses in the United States Public Health Service," Lucy Minnigerode.

October 29, 8 a.m., Round table on Ethics, followed by a Private Duty Section devoted to business and reports. Noon, Private Duty luncheon with an address by Mary M. Roberts. 2 p.m., "Registries and the Nurse" from the viewpoint of a physician; from the viewpoint of a registrar (Irma Halloway); from the viewpoint of the nurse. Report of the Study of Registries by the American Nurses' Association, Susan C. Francis. 8 p.m., Banquet with speakers—Clara D. Noyes, American Red Cross, and Annie W. Goodrich, Yale School of Nursing.

October 30, Business meeting of the State League with an address "Staff Education," Nellie X. Hawkinson, Cleveland. Noon, luncheon, with a discussion of "Group Nursing" led by Camille B. Fulper. 2 p.m., Address, "Mental Hygiene and Psychology," Dr. Arthur H. Ruggles, Consultant of Mental Hygiene, Department of University Health, Yale University, New Haven, Conn. 3 p.m., Round table, "Mental Hygiene and Psychology for Nurses," Dr. George J. Wright, St. Francis and Mercy Hospitals, Pittsburgh. 8 p.m., Address, "Personality," Thyrsa Amos, Dean, University of Pittsburgh, Pittsburgh, Pa.

October 30, 9 a.m., Business meeting of the State Organization for Public Health Nurses. 10 a.m., Round tables on School Nursing, Conservation of Vision, Rural Nursing, Staff Nurses, Industrial Nursing, Executives and Supervisors, Staff Education, Trends in Contract Nursing. 10 a.m., Meeting of Lay Section followed by a luncheon. 12.30, School Nurses' luncheon.

2 p.m., Mental Hygiene, "Building a Mental Hygiene Program in a Community," Dr. William C. Sandy, Harrisburg; "The Care of the Child in a Mental Institution," Dr. Henry Klopp, Allentown State Hospital; "The Work of Mental Hygiene in a Visiting Nurse Association," Katharine Brownell, Scranton. 4.30 p.m., A trip through the Allentown State Hospital; Business session. 8 p.m., "Appraising Your Community," Sophie Nelson, President, National Organization for Public Health Nursing.

Tennessee: The TENNESSEE STATE meeting will be held at the Hotel Andrew Jackson in Knoxville, October 13 and 14.

Vermont: The semi-annual meeting of the VERMONT STATE NURSES' ASSOCIATION will be held October 16, afternoon and evening, at Brattleboro, at the invitation of the Brattleboro Memorial Hospital Alumnae Association. The Alumnae Association of the Randolph Sanatorium has been welcomed as a member by the State Association.

West Virginia: The WEST VIRGINIA NURSES ASSOCIATION will hold its annual meeting in Fairmont, October 23–25.

District and Alumnae News

Iowa: Des Moines.—DISTRICT 7 resumed its meetings after the summer vacation on September 4. The program consisted of travel talks by members. Florence Wesslund was elected First Vice President to fill the unexpired term of Mary Ella Chayer, who took up her duties as an instructor at Columbia University with the opening of the summer term.

Maine: Portland.—The WESTERN DISTRICT ASSOCIATION held the September meeting on the 10th, at the Queen's Hospital, Portland. Delegates were elected for the State Convention. Membership to the District was increased by the addition of two new alumnae associations, one from the State Street Hospital and one from the Queen's Hospital. The program consisted of a lecture on "Psychology" by Rev. Samuel M. Donovan.

Michigan: Detroit.—The DETROIT DISTRICT has the following program for its meetings for the present year: September 5, 8 p.m., Alger Club Center—Reports of the Biennial Convention by Mrs. Louise Feist, Gladys Garrison, Mrs. Lena Schmidt, and Olive Sewell. October 3, 3.30 p.m., Crafts Guild—Demonstration of the Work of the Guild. November 7, 8 p.m., St. John's Parish House—The Nurse in Her Community: "The Course in Public Health Nursing in Detroit," Katherine Faville; "Being a Citizen in 1930," Mrs. Beth Fay Adams. December 5, 8 p.m., Henry Ford Hospital—"The Nurse as an Investor," A. B. Pfleiderer. January 9—Annual Meeting. February 6, 8 p.m., St. John's Parish House—"The Nurse in Industry," Mrs. Gertrude Hodgson. March 6, 8 p.m., St. John's Parish House—The Nurse in National Affairs, "The White House Conference," Winifred Rand; "The U. S. Indian Service," Elinor Gregg. April 3, 8 p.m., Harper Hospital—"The Obligation of Schools of Nursing in Preparing Students for the Different Fields of Nursing Services," Grace Ross, Emilie G. Sargent, Lyda W. Anderson, E. Charlotte Waddell, Esther Hillock; "How the Schools of Nursing Are Endeavoring To Meet These Obligations," June Ramsey, Juliet George. May 1, 3 p.m., St. John's Parish House—"The Nurse in World Affairs."

Minnesota: Minneapolis.—Marion L. Vannier, for fourteen years associated with the University of Minnesota School of Nursing, resigned in August to live at her home in Sierra Madre, Calif. Miss Vannier succeeded Miss Powell as Director of the School. A graduate of Johns Hopkins School of Nursing and of Teachers College, Columbia University, Miss Vannier has left a lasting impression on nursing in Minnesota, and the school has made notable progress under her direction. During recent years the results of successful studies made by various members of her staff, through her stimulating influence, have been made available to the profession. She is succeeded by Katherine J. Densford.

Mississippi: Laurel.—Mrs. Maude Varnado has leased the Laurel General Hospital and has resigned from the position she has held for many years at the South Mississippi Infirmary.

New Hampshire: Manchester.—The quarterly meeting of the SACRED HEART HOSPITAL ALUMNAE was held on July 22, with twelve members present. Reports of officers showed the Association to be in good condition. For the past two years every graduate has become a member of the Association. Annie Hayes gave a report of the last state meeting. There was discussion of many matters of interest.

MARION L. VANNIER, R.N.

Hanover.—MARY HITCHCOCK MEMORIAL HOSPITAL held graduation exercises for a class of eleven on September 6. Stella Goostray of the Children's Hospital, Boston, gave the address.

New Jersey: Paterson.—Mildred H. Maier, graduate of Mercy Hospital, Chicago, has been appointed Instructor and Supervisor at St. Joseph Hospital. Mrs. Alvina Todd, Mercy Hospital, Omaha, is Assistant Superintendent of Nurses.

New York: Binghamton.—DISTRICT 5 held a meeting on September 8 at the Wilson Memorial Hospital. The treasurer reported that the sum of $298 had been sent to the Nurses' Relief Fund. Plans for a membership campaign were discussed and approved. The program consisted of a report of the Biennial Convention by Neva Ash, also an interesting talk by Dr. Arthur S. Chittenden on his recent tour of famous French spas. The members regret the transfer of Tompkins County from District 5 to District 3. This transfer was necessary as a matter of convenience to nurses of Tompkins County.

Elmira.—Ethel Phillips has become Executive Director of the Visiting Nursing Association and Tuberculosis Committee. Miss Phillips was for nine years a member of the staff of the Public Health Nursing Association of Rochester. **New York.**—The Board of Managers of the BELLEVUE SCHOOL OF NURSING has engaged Blanche Pfefferkorn for a year's work to make a survey of the Bellevue School. The survey will include nursing care time studies and probably certain other projects related to the nursing service of Bellevue Hospital. A committee to whom Miss Pfefferkorn may report and from whom she may seek advice has been organized with the following personnel: three members of the Board of Managers, Mrs. William Church Osborne, Mrs. Linzee Blagdon and Miss Blanche Potter; four nurse educators, two from the school of nursing and hospital nursing field, Annie W. Goodrich and Carrie M. Hall, and two representing public health nursing, Grace Anderson and Mary Beard; Dr. Mark Fleming, General Medical Superintendent of Bellevue Hospital, and Marian E. Rottman, Director of the Division of Nursing, Department of Hospitals, City of New York. **Oswego.**—The regular meeting of DISTRICT 4 was held on September 8 at Oswego. Preceding the business meeting, Dr. William A. Groat of Syracuse, one of the foremost authorities on diseases of the blood in Central New York, spoke on "Anemia." He illustrated his interesting and valuable paper with lantern slides. Dr. George A. Marsden of Oswego then read a very interesting paper on "Rickets." District 4 is very busy with plans of the coming convention. Everyone is working hard to make this important event a success. **Trudeau.**—TRUDEAU SANATORIUM held graduation exercises for a class of nine on August 28. The exercises were followed by the dedication of Reid House, the new nurses' home. **White Plains.**—The BURKE FOUNDATION is erecting, in its convalescent institution, a building for recreational therapy and remedial social activities, designed particularly for use under all inclement weather conditions. Its occupancy, in the near future, will release certain spaces to an increase of bed capacity for women patients.

North Carolina: Asheville.—The regular meeting of DISTRICT 1 was held on August 13, with good attendance. The recommendation of the Registry Board that a small Executive Board be created to advise with the Registrar on routine business, and report to the Registry Board semi-annually, was presented, and after consideration, adopted. A copy of Miss Geister's letter on the revision of the by-laws of the American Nurses' Association was read and discussed. A letter from Dora M. Cornelisen in regard to subscriptions to the *American Journal of Nursing* was also read with interest.

Ohio: Painesville.—Helen L. Kintner sailed for China in August. She is to be Supervisor of Nurses at Tunghsien Hospital.

Oklahoma: Guthrie.—At the end of the summer session, the A.B. degree was conferred by St. Joseph's College on four nurses, Sister M. Augustine, Sister M. Clara, Sister M. Pancratia, and Sister M. Francis, of St. Anthony's Hospital.

Deaths

Mrs. Grace Mahoney Allen (class of 1926, W. W. Backus Hospital, Norwich, Conn.), on August 26, following an illness of one week. Mrs. Allen was ever ready to serve. She leaves a wide circle of sorrowing friends.

Helena F. Brady (class of 1912, Rochester General Hospital, Rochester, N. Y.), on August 31, at the Government Hospital, Oteen, N. C., where she had been ill for three months. Miss Brady was a well known private duty nurse, doing her work in Rochester, except when she went overseas with Base Hospital 19. Burial was at Brockton, Mass.

Helen M. Cook (class of 1926, Bridgeton Hospital, Bridgeton, N. J.), at Bridgeton Hospital, August 29, after nearly two years of illness. Miss Cook as a student, and later as a graduate nurse doing private duty, stood out as a fine Christian character and a thorough, thoughtful nurse. Her memory will remain an inspiration to all who were so fortunate as to know her.

Maud L. Eiler (class of 1925, W. W. Backus Hospital, Norwich, Conn.), on August 22, following four months of illness. Miss Eiler was ever faithful in service to others.

Mrs. Roy Higginbottom (Alma Hixon, class of 1919, Rockford Hospital, Rockford, Ill.), on July 1, at Rockford Hospital, after a short illness. Mrs. Higginbottom actively engaged in her profession until her marriage in 1928. For the past three years she had been president of her alumnae association. She will be sorely missed by a great circle of friends.

Mrs. Bertha McLain (class of 1913, Rebekah Hospital, St Louis, Mo.), on June 20, after a lingering illness. Mrs. McLain was at

first engaged in private duty, then in industrial nursing for over twelve years. As one of the faithful members of her alumnae association, her spirit and coöperation will be missed.

Bessie Margal (class of 1928, Mercy Hospital, Council Bluffs, Iowa), at her home, June 16, following a prolonged illness from tuberculosis.

Elizabeth J. Murphy (class of 1911, Chester Hospital, Chester, Pa.), on June 1, at Chester Hospital, after an illness of two weeks. Burial was with military honors at Chester. Miss Murphy was engaged in private duty for seven years and was beloved by all her patients. In 1918 she enlisted in the Army Nurse Corps stationed at Spartanburg, S. C.; she left for France in December, 1918, and was in service one year. At the time of her death she was Supervisor of the Maternity Ward in Chester Hospital. She was a faithful, active member of the alumnae association and will be greatly missed.

Mrs. Mae Williamson Rogers (class of 1928, South Baltimore General Hospital, Baltimore, Md.), on May 8, at the hospital, after a short illness. Mrs. Rogers had done private duty nursing and was an active member of her alumnae association. She will be mourned by patients and friends.

Caroline Umstead (class of 1914, Montgomery Hospital, Norristown, Pa.), on June 13, in Dr. Kennedy's Hospital, Philadelphia, from secondary shock following an operation. Miss Umstead was for a time assistant superintendent of her own school, then a private duty nurse, then a public health nurse at Conshocken and later at Norristown. She was an active member of her alumnae association, having held all the various offices; she was also Chairman of the Health Committee of the Professional and Business Women's Club of Norristown. She was a fine character.

Lettie G. Welch (class of 1887, Illinois Training School for Nurses, Chicago), on August 26, of heart trouble. Miss Welch has lived in Colorado all her professional life and the state has, in her death, lost one of its most outstanding leaders. Miss Welch came to Denver in 1888 to accept the position of Superintendent of the County Hospital, now known as the Denver General Hospital. Here she did some of her most valuable work in developing the standards of the City and County Hospital and its Training School. Miss Welch contributed much to the nursing legislation in Colorado and to the organization of the State Association of which she was President for a number of years; she was also President of the Colorado State Board of Nurse Examiners for several terms. Miss Welch was always ready with an eager heart and a willing hand to raise the standards of her profession and was always deeply interested in any organization connected with the nursing profession; she was one of the organizers and a life member of the Graduate Nurses' Club and Central Registry. When Jane A. Delano reorganized the American Red Cross Nursing Service, in 1911, she was appointed Chairman of the Colorado State Committee and held the position almost continuously until her death. She also served as Chairman of the Chevrons Committee. During the World War she was Director of the Nursing Service for the Mountain Division of the Red Cross. She was probably the best informed person on Red Cross matters in that part of the country. Her ability, knowledge, and understanding were an inspiration to others and her loss cannot be estimated.

A Nurse?

On August 4, the body of a woman about 65 years old was found at the foot of Luna Falls, Niagara. In her pocket was a pencilled memorandum of the name of the editor of the *American Journal of Nursing*. No clue to the name of the unfortunate person was found except the letter S stitched on an undergarment. On the previous day this woman had visited the Millard Fillmore Hospital in Buffalo, stating that she was a graduate of the old Homeopathic Hospital and had been living "in the West." She asked to be shown the hospital and the nurses' home. The name given was understood by one of those she met to be Mary Stearns, by another Carrie Morganstearn. The impression given was that of a person not quite normal. The description given was "a woman about five feet one inch tall, of medium build with a heavy head of steel gray hair. She had an entire set of false upper teeth and several of her lower teeth were filled with gold."

About Books

SURGICAL NURSING. By E. L. Eliason, M.D., L. Kraeer Ferguson, M.D., and Elisabeth Keller Lewis, R.N. 566 pages. Illustrated. J. B. Lippincott Company, Philadelphia. 1930. Price, $3.00.

THIS book covers practically all the material for surgical nursing as outlined in the *Curriculum for Nursing Schools*. The authors aim to present not only the "how" factors of surgical nursing but also the "why" and, with few exceptions, this purpose is adhered to.

The chapters on surgical diseases begin with bones, joints, muscles, and bursae, followed by diseases of the various systems. The first chapter of this section is especially good. In the chapter on the abdomen is found a list of prefixes and suffixes pertaining to surgery.

The chapters on methods in surgical nursing, anesthetics and anesthesia, preoperative and postoperative care and complications, are interesting and give many valuable points on the nursing care of patients.

Operating room technic includes the operating room, its equipment, personnel with their duties, sterilizers and sterilization, care of utensils, instruments, et cetera. There are twenty-six very good "Suggestions for Suture Nurse."

Unnecessary seem to be the chapter on drugs and solutions and one on bandaging, as by the time students are ready for surgical lectures they have already been taught these fundamentals. The chapter on venereal diseases might also have been omitted, as this subject is taken up in a special course.

The book is interestingly written, the print is good, but unfortunately it is on glazed paper which at times is hard on the eyes. An unusual feature is found in the method of calling to attention the important facts by means of heavy type. Whether or not this is going to be approved remains to be seen. It does tend to set off the headings of paragraphs and different phases of the subject. A noteworthy feature is the two hundred and sixty-one illustrations. These include the putting on of sterile gloves, the right and wrong Fowler's position, the instillation of eye drops, the proper method of irrigating an ear, removing adhesive, the autoclave, et cetera.

This book might not be preferred by instructors as a textbook, but it would be useful for reference reading, during a course of surgical lectures, as its emphasis upon nursing care is particularly good. Also, the illustrations should prove of value in teaching.

MAY ESENWEIN, R.N.

New York.

BACTERIOLOGY FOR NURSES. Revised. By Harry W. Carey, M.D. 282 pages. Illustrated. F. A. Davis Company, Philadelphia. 1930. Price, $2.25.

THE revised edition of *Bacteriology for Nurses* by Dr. Harry W. Carey is a textbook which will be welcomed by student nurses because it is not too detailed and intricate to be understood

by them, is interestingly written, and concentrates on the subject matter of bacteriology about which they are invariably most enthusiastic —pathogenic bacteria, and the diseases they cause.

In spite of this interest, such an emphasis on the pathogenic organisms to the exclusion of useful ones must be felt as a weakness in the book. One hundred and forty-three pages of a two hundred and eighty-two-page book are devoted to disease and less than two to useful organisms. Thus the student is given no appreciation of the rôle of bacteria as a part of our general environment. Also she is not given sufficient background before she is plunged into disease.

This section will, however, prove most helpful to young students, as the information she needs is given here in a clear, concise, interesting form with prevention as a pertinent aim; whereas, in many texts on this subject, she is lost in a maze of facts not suited to her particular needs and is unable to decide what to take and what to leave.

The set-up of the book is excellent, the paper, the print, and the illustrations all being of the best. The arrangement of the material is, on the whole, logical. As molds and yeasts are larger and more easily studied by beginners than bacteria, it would perhaps have been better if Chapter XVI had been placed in the beginning of the text, as was the laboratory work on these organisms. The chapters on chemical disinfectants, infection, and complement fixation are not as clearly presented as other parts of the book.

The laboratory exercises and demonstrations, a section not found in many bacteriology textbooks, adds to the usefulness of the book. Although these exercises require more time than is usually allotted to us for the laboratory work, they contain many good suggestions which the instructor may modify to the particular needs of her class. This section would be more helpful to instructors if directions were more detailed, or if there were additional working data as to media, stains, etc. Also a bibliography would be an aid to both students and instructors.

With the assistance of reference books to supplement certain parts, this book should prove a good textbook for an elementary course in microbiology.

HELEN M. WICKER, R.N.
New York

BOARD MEMBERS' MANUAL. For Board and Committee Members of Public Health Nursing Services. 127 pages. The Macmillan Company, New York. 1930. Price, $1.25.

THE aims of this manual, which was prepared by a committee of the National Organization for Public Health Nursing, are stated to be:

> To serve as a handbook of reference for boards of directors of non-official public health nursing organizations.
>
> To suggest methods of administration adaptable to various types of public health nursing service.
>
> To guide newly elected members of the board of directors through the months when the traditions and principles of public health nursing are being absorbed.

The little volume opens auspiciously at the preface by Dr. George E. Vincent, until recently director of the Rockefeller Foundation, who cogently states the case as follows:

> For a long time it has been assumed that directing, supervising and staff nurses need professional training and guided experience. It is just beginning to be realized that board members are not necessarily congenitally and automatically endowed with capacities and aptitudes for their duties. They, too,

require special knowledge and technical efficiency.

Part I, on the organization of public health nursing, is divided into chapters on: Fundamental Principles; How to Organize; The Association; Officers—Qualifications and Duties; Committees; The Board and Finance; Board Meetings; Developing Rural Nursing.

Part II, on the administration of public health nursing associations, contains chapters on: The Board's Relation to the Staff; Regulations of Service; Relation to the Medical Profession; Relationship to National Organizations.

A suggested constitution and by-laws, an outline for board members' institutes, and a bibliography are included in three appendices.

The material is presented in helpful, clear-cut and logical form. It should have wide usefulness. The reviewer wishes, as will many readers, that an equally practical guide on the organization of nursing schools might one day be made available.

NASAL CATARRH. By W. Stuart-Low. 84 pages. Illustrated. H. K. Lewis and Company, Ltd., London. 1930. Price, 5/—.

THIS is a short book of eighty-four pages in which the author has endeavored to elucidate the etiology, signs, dangers, and treatment of chronic nasal catarrh; certainly a subject worthy of consideration, since the disease is so widespread.

By the use of marginal headings the subject matter is most accessible and clearly outlined, augmented with a few well chosen illustrations. Essentially it is technical and considerable space is given to the discussion of surgical treatment and procedures. Briefly, a summary of the chapters is as follows:

Chapter I is given to the discussion of nasal catarrh and its predisposing causes, while Chapter II deals with nasal polypi as related to nasal catarrh. The character of sinus discharges is outlined in Chapter III. The general and local treatment of nasal catarrh is discussed in Chapter IV, emphasizing the dangers of nasal douching. Chapter V, by far the longest in the book, is given to surgical treatment of diseases of the nose. Other diseases of the nose, namely, nasal blockage and septic ethmoiditis, are outlined in Chapters VI and VII, followed by their respective treatments. Serous nasal catarrh, the synonyms of which Dr. Stuart-Low lists as Hay Fever, Acute Rhinitis, Vaso-Motor Rhinitis and Nervous Coryza, are considered in Chapter VIII. For this condition nasal calesthenics are advised, consisting of a series of breathing and muscle exercises. A conclusion of the subject comprises Chapter IX.

The question may arise as to the practicability of such a book under different climatic conditions. However, there seems to be no essential difference in the signs and symptoms as outlined by Dr. Stuart-Low from those common to the disease in our own country.

ABBY-HELEN DENISON HAWES, R.N.
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Books Received

A TEXTBOOK ON THE NURSING AND DISEASES OF SICK CHILDREN FOR NURSES AND WELFARE WORKERS. By various authors. Edited by Alan Moncrieff, M.D. 580 pages. Illustrated. G. P. Putnam's Sons, New York. 1930. Price, $4.50.

M. A. Fussell, S.R.N., Sister Tutor, and an Examiner for the General Nursing Council for England and Wales, collaborated with the four contributors to this volume, all of whom are members of the medical staff of the Hospital for Sick Children, Great Ormond Street, London, England.

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